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# FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Volume 4 Issue 1 1999

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## ARTICLES

### **What Have We Learned from Articles Published in *Family Preservation Journal*?**

*Michael J. Holosko and D. Ann Holosko*

### **Family Reunion Services: An Examination of a Process Used to Successfully Reunite families**

*Lois Pierce and Vince Geremia*

### **A Multi-Dimensional Approach to Evaluating Family Preservation Programs**

*Cynthia A. Ford and Felix A. Okojie*

### **Ordinary Families—Extraordinary Care Giving**

*John P. Ronnau*

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PLUS a review of current resources



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Volume 4 Issue 1 1999

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The Family Preservation Journal is a refereed biannual publication. The Journal provides a forum for practitioners, administrators, researchers and educators to present and critically review programs, policy, practice methods, and research findings in the areas of family preservation and family support. The Journal is intended to positively impact the type and manner of services provided to families. Research and case studies from those delivering services are encouraged.

Manuscripts should conform to American Psychological Association style, with an optimal length of 18 pages, not to exceed 25 typed, double-spaced pages (excluding tables and figures), with an alphabetical list of references. Also include a diskette copy using WordPerfect v 5.1 or v 6.1, or v 8.0 for PC.

Provide five copies of the manuscripts; the title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title should appear on the abstract and first page of the text. Include an abstract of about 100 words.

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## Editorial

### Take Me Home, Down Country Roads

Those of us committed to the tenets of Family Preservation must advocate for increased awareness and attention to the needs of children and their families in rural America. "Country roads" and the rural spaces they traverse have been eulogized by many poets and song writers as ideal places to live. But they may not be ideal for everyone. The past few months, it has become all too evident that rural America is not immune to acts of extreme violence by troubled children. Even though almost 1/3 of American youth live in rural areas, they have been "virtually ignored by mental health service planners and providers" (Cutrona, Halvorson, & Russell, 1996, p. 217). Mental health risk factors such as poverty, parental alcohol abuse, and family instability are on the rise in rural areas, and there has been an increase in suicide attempts, family violence, depression, and alcohol abuse (Cutrona, Halvorson, & Russell, 1996; Petti & Leviton, 1986; National Mental Health Association, 1988). Native Americans are especially concerned about the increases in child abuse and neglect, depression, substance abuse, and suicide in their communities (Edwards, 1989).

The mental health needs of youth in frontier counties may receive even less attention. A population density of less than 7 persons per square mile is necessary to earn the designation of "frontier." Fourteen states meet the criteria for either Categories I or II in relation to their frontier populations. Category II states are those with 5 to 14% of their population in frontier counties or with a total frontier population of greater than 250,000. Among the Category II states are New Mexico, Utah, Nevada, Arizona, Colorado, and Texas (Ciarlo, Wackwitz, Wagenfeld, & Mohatt, 1996). The mental health needs of children and youth in frontier communities are typically less attended to than urban youth for several reasons. First, limited financial resources are allocated to meet the mental health needs of young people, especially in rural communities. For example, the Utah Legislature has appropriated enough funds through the state's Community Mental Health Centers (CMHCs) to meet the needs of only 1% of the state's children and youth, but it is estimated that 9-11% of the state's youth may suffer from severe emotional disability (SED) (Federal Register, 1997). Secondly, some of the same characteristics which are the strengths of rural communities (self reliance, conservatism, distrust of outsiders, religion, work orientation, individualism) may contribute to misconception and mistrust of mental health services and a reluctance to identify problems (Kelleher, Taylor, & Rickert, 1992). The third reason is that, too often, attempts are made to impose urban models for conceptualizing and delivering mental health services in rural communities. These models may be contrary to community values, natural support systems, local policy making, and administrative structures. The fourth reason is that it is very difficult for many in rural communities to access mental health services. Qualified providers, if they exist at all, may be located one to six travel hours away. Choice among providers is extremely limited. In many areas, there is only one part-time staff member who is expected to serve both children and adults. And finally, lack of cultural competence among mental health service models and providers may be an impediment.

Contrary to the stereotypes, there may be considerable ethnic and cultural diversity in rural areas. For example, there are 44 different tribes represented in the Salt Lake Valley alone. There are approximately 30,000 members of the Navaho, Ute, Paiute, and Shoshone bands in Utah. About 1/3 of these people reside in rural areas. Another 1/3 move back and forth between urban and rural areas, depending upon the season and work opportunities. Children in families that migrate to obtain work are at a particularly high risk for serious psychiatric problems (Kupersmidt & Martin, 1997). Rural communities may include many other diverse groups with strong social, religious, and political values. Polygamists, environmentalists, ranchers, farmers, and those seeking isolated living environments are but a few examples. The use of natural supports, local resources, and non-traditional services, such as traditional healers, are essential for reaching these groups. Rural communities have many strengths due to their geographical location, cultures, and heritage (e.g., historically strong networks, strong sense of community, recognition and knowledge of community members, informal resources).

There is no single solution or program that will meet the needs of all children and youth with emotional problems in rural communities (Cutrona, Halvorson, & Russell, 1996; Kumpfer, Molgaard, & Spoth, 1996). Any viable response to meeting the needs of youth with SED must be community based and holistic in nature. While research on child and adolescent mental health services is limited, two key issues have been identified. First, providing mental health services to children and youth is a complex challenge because of the "multiple points of entry into care, number of agencies involved, family roles, organization of public sector services, child maturation and development, and lack of consensus on diagnostic categories and treatment modalities" (Kelleher, Taylor, & Rickert, 1992, p. 841). Secondly, the reality is that "most youth with mental disorders are under- or inappropriately served by the current system" (Kelleher, Taylor, & Rickert, 1992, p. 842). Poverty and family disruption are becoming increasingly more common among rural youth, leading to increased numbers of health risk factors, including suicide attempts, family violence, depression, and alcohol abuse (Kelleher, Taylor, and Rickert, 1992).

Based upon their model for rural children's mental health services, Sawyer and Moreines (1995) contend that "the fundamental requirements of a rural model include the ability to identify clients and their needs, ensure access and accessibility of services, creatively and effectively use the limited number of trained professionals and resources available, and coordinate an efficient communication system" (p. 598).

Kumpfer, Molgaard, and Spoth (1996) have identified eight principles "for best practices in family programs." Four of these principles are especially pertinent to the tenets of the family preservation approach. The authors assert that to be effective, family programs must be: 1) comprehensive; 2) family focused; 3) long term; and 4) tailored to target populations' needs and cultural traditions.

For many families in rural America life is idyllic: clean air, open spaces, little traffic, and friendly caring neighbors. But for families caring for a member with a severe emotional disability, rural living may not be so grand. Essential services and providers simply may not be present in the community. Well meaning family and neighbors cannot provide the specialized and intensive resources which the youth needs. These families are often left largely



on their own to cope. If the trip home on country roads is to be a happy one for families caring for a child with SED, they will need lots of support. Social workers and other helping professionals working in rural areas face unique challenges in providing that support. They are often required to be "generalists" in the best sense of the term (Landon, 1999). Family preservation in rural areas, especially in rural frontier communities, is a very challenging job, which deserves more of our attention and resources.

John P. Ronnau

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## What Have We Learned from Articles Published in the *Family Preservation Journal*?

Michael J. Holosko and D. Ann Holosko

*This exploratory descriptive study presents a content analyses of all (N=22) Family Preservation Journal (FPJ) articles published from its inception (1995) until today. Three raters independently used an analysis template to ascertain trends from these articles and assessed information about their purposes, methods, and findings/implications. The main findings were less than half of the articles were deemed as 'research'; few used standardized or outcome measures; none compared family preservation to another method; descriptive knowledge was more likely to be generated; and the articles were primarily targeted to practitioners and other researchers. Given the relatively short history of FPJ, the majority of these findings were considered typical and consistent with the literature. The recommendations call for more comprehensive practice descriptions, more research, and more rigorous research-oriented studies.*

State-of-the-art reviews of social work journal publications have proven beneficial in discerning trends and issues about who reads the journals (Grinnell Jr., & Royer, 1983; Karger, 1983; Penka & Kirk, 1991); methodologies used by their researchers (Greenwood, 1957; Tripodi, 1984); practitioner treatment methods (Glisson, 1995; Gorey, 1996); and the role of journals in the development of the professional knowledge base (Fraser, Taylor, Jackson, and O'Jack, 1991; Lindsey and Kirk, 1992; McMahon, Reisch and Patti, 1991).

In general, all such reviews are based on the premise that professional journals are an appropriate forum from which a profession's research and knowledge base can be determined. The extent to which this premise is true is certainly questionable; however, such forums do provide for an objective (meaning checkable) point of departure for these analyses.

The reviews cited above scrutinized a number of professional journals over a time frame (5 - 20 years), and assessed social work publications in both core, e.g., *Journal of Social Service Research*, *Social Service Review*, *Social Work*, etc., as well as related affiliated journals, e.g., *Child Welfare*, *Families in Society*, *Administration in Social Work*, etc. Conspicuously absent in this literature were reviews of single subject journals over time, to discern their research trends, issues, and development.



The purpose of this study was to conduct an analysis of the *Family Preservation Journal* (FPJ) in order to answer the question—"What have we learned from FPJ publications?"<sup>1</sup> The editorial board of FPJ inspired this initiative as they wanted to determine trends reflected in the journal, given its relatively short history (4 years), and given the importance of family preservation in current social policy, programs, and practice in the U.S.A. The objectives of this exploratory descriptive study were

1. to assess the purpose, method and findings of studies in the FPJ,
2. to assess issues related to research and practice knowledge, and
3. to offer recommendations to authors based on this review.

### Method

#### The Sample

Five FPJs were analyzed in this study. These included one published in 1995 (Summer), one in 1996 (Winter), two in 1997 (Volume 2, Nos. 1 and 2), and one in 1998 (Vol. 3, No. 1). These represented all of the FPJs published to date, and in this set, there were a total of 22 refereed articles (N=22).

#### Analysis of Articles

The authors expanded on an analysis framework developed by Rosen, Proctor, and Staudt (1998), who reviewed 13 social work journals (from 1993-97), which included N=1,849 articles. This study [the present one] developed an analysis template of 19 structured and open-ended questions based on the three related phases of the research process: purpose → method → findings. The purpose was assessed according to its clarity and specification and whether it was stated or not. The method was assessed from the standpoint of research vs. non-research<sup>2</sup>, its clarity, instrumentation, design, replication, how data were collected, family preservation intervention comparisons, use of outcome measures, and degree of specificity of outcomes. The findings were analyzed according to specificity of implications, dissemination audiences, types of knowledge<sup>3</sup>, and the main things learned from the study.

#### Data Collection

Three readers (N=3) were each given a set of all 22 articles [with the author's names deleted], definitions of terms used in the analyses, and a training session. The latter took about 1.5 hours and focused on using the template (with 4 social work articles not used in the present review), the importance of working independently, and confidentiality. None of the raters had previously read any of the FPJ articles they assessed. After all of the 22

articles were independently analyzed by the raters, a 94% degree of inter-rater reliability was determined across the 19 assessed items in the analysis framework. Subsequently, all members of the research project met and discussed the discrepancies. After some discussion, all unanimously agreed on the reassessed discrepancy items.

### Results

Table 1 presents the type of research and methods of the 22 articles assessed.

**Table 1**  
**Type of Research and Methods Used: *Family Preservation Journals* (FPJs) 1995 - 1998**

I. Type	Percentage (%)
a. Research	41
b. Non-research	59
II. Methods Used	
a. Quantitative	18
b. Qualitative	64
c. Both Quantitative & Qualitative	18

By further breaking down "research type" in Table 1, Table 2 subcategories the research designs used, as well as the non-research articles.

In regard to the research articles in Table 2 ('Research Designs'), in 77% of these articles, one could not replicate the interventions used [as described] in these studies, 23% used standardized measures (on average 2 per research article, when noted) and 41% used outcome measures (on average 3 per study, when noted).



**Table 2**  
Research vs Non-Research Articles in *FPJs*: 1995 - 98 (N=22)

I. Research Design <sup>a</sup>	Percentage (%)
a. Exploratory	12
b. Quantitative-Descriptive	44
c. Quasi-Experimental	44
d. True Experimental	0
<b>II. Non-Research</b>	
a. Literature Reviews	15
b. Conceptual/Practice Frameworks	23
c. Case Analyses	54
d. Instrument Development	8

Table 3 presents the specificity of purpose, method, and study implications of the articles reviewed.

**Table 3**  
Degree of Specificity of Purpose, Method and Implications of *FPJs*: 1995-98 (N= 22)

Specificity	Percentage (%)	
	Yes	NO
a. Purpose	64	36
b. Method	45	55
c. Implications	59	41

Table 4 presents the types of knowledge assessed in these articles.

**Table 4**  
Types of Knowledge Assessed in *FPJs*: 1995-98  
(N = 22)

Types of Knowledge	Percentage (%)
a. Descriptive	55
b. Exploratory	9
c. Influence/Control	36

Table 5 presents the main target audiences rated by different groups for the studies assessed.

**Table 5**  
Main Target Audiences for Overall Study Implications in *FPJs*: 1995-98 (N = 22)

Audiences	Target Group (%)		
	1 <sup>st</sup> Group	2 <sup>nd</sup> Group	3 <sup>rd</sup> Group
a. Clients	-	6	7
b. Practitioners	62	19	-
c. Supervisors	-	6	7
d. Administrators	5	12	21
e. Policy-Makers	5	19	-
f. Agency Boards	-	-	-
g. Communities	-	6	-
h. Program Planners	5	6	21
i. Researchers	23	19	36
j. Funders	-	-	-
k. Prof. Assns.	-	-	-
l. Other Agencies	-	6	7

Finally, raters were asked to state in one [plain English] sentence, what was 'the main thing learned' from each study. These results were then summarized accordingly: 40.9% stated more research is needed; 31.8% stated better (more rigorous ) research is needed; 13.6% indicated that family preservation interventions were effective with specific client groups



or family situations (e.g., lesbians, family reunification processes, etc.); and 13.6% revealed 'other issues' (e.g., the need for more family preservation training, ethical standards, more theory to guide practice, etc).

### Discussion

The findings and generalizability of this study should be tempered with some preliminary comments. Foremost, family preservation principles have deep roots in the historical traditions of social welfare practice in the U.S.A. (Adams, 1910; Baker, 1910; Richmond, 1917). The extent to which the cohort of articles reviewed in this study actually reflect the research, knowledge, and practice issues in this field is unknown. Second, this study presented a content, not meta-analyses, of the respective *FPJ* articles [for an excellent meta-analyses of this subject, see Fraser, Nelson, and Rivard (1997)]. Although this analysis was perceived as thorough and inclusive, it is certainly limited by the criteria used in this study.

Turning to the results of the study, Table 1 reveals that 59% of the published articles were categorized as non-research. Although this may seem surprising to some, it is consistent with Rosen, Proctor, and Staudt's (1998) review of 1,849 social work articles, which revealed that 53% were similarly deemed non-research. The extent to which these non-research articles generate relevant knowledge for practitioners is certainly a debatable topic for the philosophers of science and beyond the scope of this discussion. However, few would deny, regardless of where they find themselves on the empirical-science continuum, that practice research developed by the core practitioners can do nothing more than enhance practice (Wodarski & Thyer, 1998). Table 1 also reveals that of the research articles published 64% were qualitative, 18% were quantitative, and 18% were both. The high percentage of qualitative articles, which included individual case analyses, would seem to reflect the exploratory level designs of practitioners working in this field. Additionally, the current research trend of both methods (quantitative and qualitative) reiterated the necessity for family preservation researchers to be both flexible with their designs and 'take the problem where it is at' (Holosko and Leslie, 1998). This is consistent with the uniqueness of much social work research and may be indicative of the fact that the primary authors of these articles were most likely to be social work academics.

Table 2 reveals that when research designs were used, they were likely to be quantitative-descriptive (44%) or quasi-experimental (44%)—in short, the correlating/associating or testing of variables. The complete absence of true experimental designs most likely reflects the reality of their lack of appeal, suitability [ethically], and feasibility to researchers working this field [a point with which we certainly concur]. Table 2 also reveals a small

percentage (8%) of the *FPJ* articles devoted to instrument development in this field—again reflecting a developmental evolution of research in this field, as was previously noted.

Surprisingly, in 36 % of the articles reviewed, the purpose was not clearly stated (see Table 3). Similarly, neither was the method (55%), nor the implications (41%). This is not to suggest that these articles had unclear purposes, methods, and/or implications, but it is to suggest that these features were unclearly stated. Given the necessity for specification in research and the fundamental relationship between the component parts of any research process: purpose → methods → findings → implications, authors in this field should heed these caveats. In addition, given that a basic social science research tenet is replicability and generalizability, these deficiencies become even more magnified. A further confounding issue is that in 77% of the studies reviewed, one could not replicate the intervention(s) specified.

Regarding the use of standardized or outcome measures, few research studies reported their use. Specifically, only 36% used any standardized measures, and 41% of the studies reported the use of outcome measures. The latter were further assessed according to their degrees of specificity on an ordinal scale. In this regard, 54% were deemed as "low" or were "unguided observations, content analyses, or self-reports" (Proctor, 1998 p. 16); 23% were deemed "medium" specificity or were "non-standardized rating scales developed for the study whether by clients, workers, or researcher (e.g., goal attainment, satisfaction, improvement), or definition-guided observations (e.g., client behavior records)" (Proctor, p. 16). Furthermore, it was surprising that in 100% of the articles reviewed (research and non-research) in *not a single case* was family preservation intervention compared with any other intervention or method. It would appear that the critical necessity to specify intervention and outcomes in research (Wodarski & Thyer, 1998), is indeed a necessary first step in testing the efficacy of any intervention. However, in this cohort of studies reviewed, neither specification nor testing efficacy with other interventions was apparent.

Given the above methodological shortcomings, it was not surprising that the majority of knowledge (type) generated from the *FPJ* articles were (as indicated in Table 4), 'level 1' or descriptive knowledge (55%). This type of knowledge "guides the classification of phenomena into meaningful conceptual categories" (Proctor, 1998, p.7). The second ranked knowledge type was 'level 3' or influence/control knowledge (36%), which "identifies means of influencing events or behavior; the direction of influence can be maintenance (prevention) or change (intervention -increasing, decreasing)" (p.7).

In regard to the latter finding, Rosen (1993) and Proctor, Rosen, and Straudt (1998) make a compelling argument for the necessity of more influence/control knowledge to enhance



the practice knowledge of the social work profession. The review of these *FPJ* articles found that more than a third of them achieved this goal. This figure was more than double the 15% that Protor, Rosen, and Straudt (1998) reported in their comprehensive review previously cited. As a result, it was interesting to note that despite the methodologic shortcomings previously stated (re: low specificity, lack of standardized measures and outcomes, lack of intervention specificity or comparative testing, etc.), these features did not deter from their ability to produce practitioner influencing types knowledge. This was indeed a commendable feature of the *FPJ* articles reviewed.

Table 5 reports on the target audiences of these studies (ranked 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup>). From a cumulative (frequency) standpoint, practitioners would rank first, followed closely by researchers, then administrators and policy makers. Conversely, no implications were directed at all to any agency boards, funders, or professional associations—the very groups who tend to hold the most political clout for public accountability and social policy. Further, only 6% of the articles reviewed were targeted toward communities, and 13% had implications for clients, supervisors, or other agencies.

From the standpoint of an overall review, Table 5 can be interpreted as follows: since this is a "practice journal" [in every sense of this term], *FPJ* authors are compelled to target front-line practitioners as their main target audience. Indeed, this an editorial policy of the journal. The extent to which family preservation practitioners actually read these articles and incorporate this knowledge is questionable and warrants further research. We make this point because these *FPJ* authors are primarily social work academics, and it has been well documented that collectively this group tends to write for other academics and researchers as their primary audience (Grinnell Jr. & Royer, 1983; Karger, 1983). Such a convention does not, and will not, improve and/or refine the overall practice conceptual frameworks and skills of its front-line practitioners. As family preservation grows into a more widely accepted practiced intervention, it will be imperative that family preservation practitioners stay current via research to build and maintain a certain standard of practice. The probability that this journal may fall into the trap of researchers writing for researchers was also clearly evidenced in the recommendations for "more research" and "more rigorous research" as being the number 1 and 2 rated things "learned from each study." And so, the longstanding schism identified between practitioners and researchers prevails in these articles (Holosko and Leslie, 1998). That is, it is researchers who are most likely to read the research published in professional journals, not the practitioners for whom the articles are intended (Rosenblatt, 1968; Penka & Kirk, 1991).

A final concern was the lack of attention devoted to the ultimate consumers of our helping efforts—clients and also the lack of attention to funders, agency boards, communities, and

professional associations reflected in the articles. In this age of relevance and accountability, as well as consumer empowerment, such groups certainly should be more meaningfully addressed in future research endeavors of this nature (Holosko, 1997).

### Recommendations

The recommendations from this review will be listed summarily with a brief rationale for each. They are presented as non-mutually exclusive research suggestions emanating from the previous review.

### Practice Descriptions

1. *Day to day practice descriptions:* Clear descriptions of simple day-to-day family preservation practices should be offered, preferably in case analyses form. Such descriptions should be used to guide and inform practitioners working in this field.
2. *What doesn't work?* Family preservation researchers should be willing to bare their accounts of what didn't work in practice for the same reasons noted above (#1). In this same context, the limitations of this approach should be clearly specified to inform others of strengths and weaknesses in different practice contexts.
3. *Practice accounts with diverse client groups:* A broader range of research on family preservation practice with diverse client groups is needed. The *FPJ* journals reviewed [here] imply, for the most part, that these are lower income families, white, with one "problem child," and they all desire to have family preservation intervention to prevent 'disrupting' the family unit. The incorporation of more diverse client-based perspectives into all such accounts is recommended—as these are the ultimate consumers of our efforts.

### Research and Research-Oriented Studies

1. *Comparing Family Preservation interventions:* Studies comparing family preservation to other interventions are sorely needed. The ability to generalize about family preservation is increasingly enhanced when it is compared against another interventions.
2. *More rigorous research:* More controlled studies using larger sample sizes, comparison groups, standardized and outcomes measures, and longitudinal designs are recommended. Better quality research not only enhances the ability to produce better



knowledge, but it cultivates a research-knowledge orientation to the field, which can only enhance its credibility.

3. *Program evaluations*: More systematic and comprehensive evaluations of family preservation programs are recommended. These include process (ongoing program functioning), outcome (assessing impacts), and efficacy studies (assessing cost effectiveness data). Both the public and funding bodies should have a vested interest in evaluations of this nature.
4. *Community and interorganizational studies*: Given the fact that family preservation interventions are so intimately tied to communities, other agencies and their resources, such studies are recommended. Given the government's devolution of social welfare programs back to communities, neighborhoods, family and personal networks, such studies would bode well in the current political climate.
5. *Policy analyses*: Critical macro, meso, and micro analyses of family preservation policies are needed. These should include local, regional, statewide, or federal auspices.
6. *National data bank*: Finally, it is recommended that a national bank of all family preservation programs be developed to serve as an information and research repository of such programs. This would centralize and make accessible a variety of information and data about family preservation programs to anyone, anywhere in the USA or worldwide.

#### Endnotes

1. A preliminary draft of this study was presented at the Family Preservation Annual conference in Sept/98, Houston, Texas. Suggestions from this presentation were incorporated into this article.
2. Research vs. non-research - Research articles were classified as ones containing the usual components in research reports, such as study questions, or systematic methodology and data gathering procedures, and report findings. If some of these components were missing, yet the author referred to the article as a report of a research study and presented original findings, the article was classified as research. Reports on single-system studies were included as research articles, we were replicable, systematically conducted meta-analyses of prior research reports. Not considered as research articles were non-systematic reviews or syntheses of the literature, narrative-

only case studies, and articles dealing with research methodology only, without a substantive focus (Proctor, 1998, p.10).

3. Type of knowledge: Descriptive: Guides the classification of phenomena into meaningful conceptual categories, (e.g., rates of poverty, prevalence of child abuse).  
Explanatory: Guides understanding of phenomena—their interrelationships, factors influencing their variability, and their consequences, (e.g., relationship between depression and functioning, factors associated with hospital readmission).  
Control: Identifies means of influencing events or behavior; the direction of influence can be maintenance (prevention) or change (intervention—increasing, decreasing), (e.g., studies of prevention, demonstration of effects of intervention).
4. Based on the main design typologies developed by Tripodi, Fellin & Meyer (1969).

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## Family Reunion Services: An Examination of a Process Used to Successfully Reunite Families

Lois Pierce and Vince Geremia

*Family Reunion Services, an intensive-home-based service for families whose children are unlikely to return home without additional services, was evaluated. The 196 children who received FRS services and remained home had fewer previous placements, were more likely to be black and to come from families where the FRS worker intervened in the areas of parenting skills or communication. FRS workers' activities are described.*

Although we have always believed that the best place for children is in their own homes (Kadushin, 1980), and, in spite of federal policy to ensure that children are placed only when necessary, the use of foster care has grown during the past decade (Ahart, Bruer, Rutsch, Schmidt & Zaro, 1992). While many children who enter care return home and remain at home, a relatively large number either never exit alternative care or re-enter care (Maluccio, Krieger & Pine, 1988; Rzepnicki, 1987; Tatara, 1992). Children may remain in care because the child welfare system is overloaded and unable to respond to families with multiple problems. Other studies suggest children may re-enter care because there are few services available once families are reunified (Ahart et al.), because parents have not resolved ambivalence about the child's return home (Hess & Folaron, 1991), or because the child's problems have not been resolved (Fraser, 1991). When there are few services offered, families often revert to the problems that caused children to enter care initially.

A number of family reunification programs have been developed using intensive, family-centered, home-based services (Frankel, 1988; Hodges & Blythe, 1992) as a way to respond to the lack of services available to families with multiple problems. In 1992, Ahart et al. described 9 programs they had reviewed for the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services as part of an exploratory study on intensive family reunification programs. One of the major problems found by the team was no common definition of family reunification, which makes it difficult to compare and evaluate programs. In fact, the team found a wide range of reunification success rates—38% after 2 years to 74% after the first year.

Even more difficult is trying to compare families that have experienced more than one placement with families whose children remain home after the first placement. As Ahart et



al. (1992) and Rzepnicki (1987) point out, foster care places additional stress on families, and families who have children placed more than once are likely to be those with the most serious problems and the most difficult to work with.

Few programs have published results of their family reunification services. Fewer still have provided a process evaluation or analyzed how the program worked. One of these is the process analysis described by Lewis, Walton, & Fraser (1995) in which the Utah State Department of Human Services used the Homebuilders™ model of brief intensive family preservation services to reunite families after a child had been removed from the home. At the time of the 12-month follow-up, 77% of the children in the family reunification program had returned home compared to 49% in a control group. Lewis et al. conclude that, while the process of family reunification services is similar to that of family preservation, it may be more efficient in changing foster care utilization.

Efficient foster care utilization has been mandated by the Adoption and Safe Families Act (H.R. 867), which reemphasizes the philosophy that foster care is a temporary, not permanent, solution to care for children whose families are unable to provide a safe environment. The ASFA allows states to provide concurrent planning for reunification and adoption and requires that a child's case plan must include steps being taken to achieve permanence. The ASFA ensures that foster care will be temporary by requiring, in most cases, that states file for termination of parental rights after a child has been in care for 15 of the last 22 months.

Although the program described in this article was developed before passage of the ASFA, the program provided resources and services to families of children who had been in foster care for longer than six months and who were judged unlikely to return home in the near future. Children who remained out of care after the program are compared to those who reentered care to see which components of the program contribute to its effectiveness.

### **The Family Reunification Services Program**

In an attempt to respond to increasing numbers of children residing in out-of-home care, the Missouri Division of Family Services (DFS) developed a family reunification program in 1994. Family Reunion Services (FRS) is based on the use of intensive preservation services with families whose children were unlikely to return home within six months without intensive intervention. This article describes the process used to implement the program.

FRS, as structured by Missouri, is a short-term, intensive, family-based program designed to reunify with their family children who are in out-of-home care and who, as mentioned

earlier, are unlikely to return home in six months. The goals of FRS are to assist a family in removing barriers to the return of their children, assist in the transition of returning the children to the family, and develop a plan with the family that will maintain the children safely in the home for at least one year following the intervention.

The families targeted for FRS are those for whom reunification is unlikely if the family receives traditional alternative care services. The decision to focus on this population is based on the finding that the likelihood for reunification decreases and the likelihood for more restrictive placements increases the longer children remain in care.

FRS provides intensive case services for 60 days (with the possibility of a 30-day extension) to families and children. Family reunification specialists are available to the family 24 hours a day seven days a week. Hours of direct face-to-face service intervention average 13 hours a week over the course of the intervention. Services are home-based and focus on the family. To allow specialists to provide the intensive services associated with FRS, caseloads are limited to three families.

Families are selected for FRS after being referred by their DFS worker and screened by an FRS team that includes representatives from DFS, FRS, and in some counties, the court. The safety of the child must be ensured, and parents who are abusing substances must participate in a treatment program before being eligible for FRS. Within the first two weeks after FRS begins, children return home and the FRS specialist works with the family to make changes necessary for the child to remain home.

### **Methodology**

All Family Reunion Services cases opened in St. Louis City and County and Jackson County (Kansas City) between July 1, 1994 and January 31, 1996 were included in the evaluation—312 children from 169 families. Children who exited care were followed for 16 months following their exit date, the time within which almost all children in Missouri who reenter care have reentered care. Those who subsequently reentered care were compared to those who didn't.

In addition, the FRS children were compared to a group of children in traditional alternative care who were matched to them on age, race, gender, and date of first entry into care. Information on the number of previous placements and length of time in care prior to the start of FRS indicated the FRS group had been in care for a longer time and had significantly more placements than the traditional care group. The emphasis of this article



though will be on the comparison of the FRS children and their families before and after FRS.

Evaluation data were collected from FRS records (assessment and process information), and interviews with FRS specialists and FRS parents. In addition, three instruments were used to collect information on the family and children: the Walmyr Index of Parental Attitudes (IPA) and Index of Family Relations (IFR) (Hudson, 1982), and the Piers-Harris (Piers & Harris, 1964). These instruments were administered by the FRS specialists, and informed consent was explained to the families and signed consent forms obtained before any questionnaires were completed. Specialists indicated that 6 families refused to participate. The analysis for this study was based on two data sets. One, which included only the FRS children, merged information from two forms developed for the project, from the specialist's narrative, and from the scores on the research instruments. The second data set, from the Missouri Department of Social Services Research and Evaluation unit, included information on all placements of the FRS children and the children in the traditional care comparison group. When examining family variables, only one child from each family was used.

### Description of FRS Children and Their Families

The families served by FRS can be described as poorly educated and as having little income (see Table 1). The majority of the parents (61%) had less than a high school education. Sixty-four percent of the families had a monthly income of less than \$800 a month, with 23% of those families receiving less than \$400. Sixty-five percent of the parents did not have a partner living with them, and the majority of families had one (36%) or two (23%) children in care.

In addition to the usual demographics, workers were asked to list up to five family characteristics or barriers that prevented the child's return home. Although there were 40 possible categories, the following were listed most frequently—poor parenting skills (62%), stress (46%), lack of problem-solving skills (37%), communication problems (37%), substance abuse (34%), employment (31%), and housing (27%).

The FRS children (see Table 2) were more likely to be female (56%) and to be African-American (77%). The average age of FRS children was 8.2 years with participants averaging 5.8 placements overall—5 placements before FRS and 1.4 placements for the 115 children (37%) who were placed after FRS.

**Table 1. Description of Family Reunion Services Families\*  
(N=169)**

	N	%
<b>Education</b>		
No high school diploma	96	61
High school graduate	41	19
GED	9	6
Some college	22	14
<b>Income Level</b>		
Less than \$400/month	28	23
\$401-\$800/month	50	41
\$801-\$1200/month	24	20
Over \$1201/month	19	16
<b>Children in Care</b>		
One child	63	37
Two children	41	24
Three children	35	21
Four children in care	18	11
More than four	12	7
<b>Family Characteristics (Barriers) Keeping Children from Returning Home (5 Possible Responses/Family)</b>		
Poor parenting skills	105	62
Stress	78	46
Lack of problem-solving skills	63	37
Communication problems	63	37
Substance abuse	57	34
Employment	52	31
Housing	46	27
Parent-child conflict	41	24

\*Some totals are less than 169 because of missing data.



The FRS children were more likely than those in the comparison group to be in care because of physical abuse (27% compared to 21%), parent abandonment (17% compared to 9%) and sexual abuse (14% to 13%), and less likely to be in care because of physical neglect (22% compared to 32%). Other reasons for enter into care include the parent's request and incorrigible behavior.

### Results

For those children who returned home after FRS, 63% did not re-enter care.

### Comparison of Children Who Returned to Care with Those Who Didn't

Discriminant analysis, which allowed us to determine which variables contribute the most to the difference between two groups, was used to compare those children who returned to placement with those who didn't. The variables examined, number of placements before FRS, length of time in placement before FRS, and the child's race and age, were able to significantly differentiate between the two groups ( $X^2=14.11$ ,  $df=4$ ,  $p=.007$ ). Children who returned to care after FRS were more likely to have more placements before FRS, to be white and to be older. Interestingly, length of time in care contributed little to the difference.

### Barriers to Return Home

When the barriers checked most often by DFS workers—stress, parenting skills, lack of problem solving skills, and communication problems—were combined in a discriminant analysis, they were able to significantly differentiate between those children who returned home and those who didn't ( $X^2=28.75$ ,  $df=4$ ,  $p=.000$ ). Lack of problem solving skills and parental stress contributed the most to the difference, with children whose parents have poor parenting skills and who are experiencing stress being most likely to return to care. But when the barriers to return to care were combined with the child variables, the child variables—the number of prior placements, the child's race, and the child's age—remained the most important in differentiating between the two groups ( $X^2=16.99$ ,  $df=5$ ,  $p=.005$ ).

**Table 2. Comparison of FRS Children Who Reenter Care Post-FRS and Their Families to Those Who Don't and Their Families**

	Remain Home (N=196)	Placed (N=115)	Total (N=312)*
<b>Child Variables (N=312)</b>			
Mean number of times placed	4.7	7.9	5.8
Mean days in care overall	864	1263	1010
Mean number of times placed prior to FRS**	4.7	5.9	5.0
Mean days in care prior to FRS	864	955	902
Mean number of times placed post-FRS		1.4	1.4
Mean length of time in care post-FRS		81	81
Age (in years)**	7.7	9.9	8.2
Race**	85%	65%	
African American	15%	35%	
White			
Sex	47%	43%	
Male	53%	57%	
Female			
<b>Family Variables (N=169)</b>			
Family barriers to return home***	N	%	N %
Communication	73	38	
Poor parenting skills	51	27	
Lack problem solving skills	46	24	
Stress	45	23	
Housing			31 30
Parent/child conflict			26 25
Child unmanageable			22 21
Areas of intervention***			
Communication	60		
Poor parenting skills	41		
Lack problem solving skills	43		
Stress	41		
Housing			24 30
Parent/child conflict			20 25
Child unmanageable			18 23
Had specialist goals	57	77	17 23
Achieved goals	40	54	14 19



### Process Analysis

To better understand how the program obtained the results it did, we examined more closely how the components of the FRS program operated. The first step for families to become involved in FRS was referral to the program by their DFS case manager. Each case was reviewed by a team of DFS staff and representatives of the reunification staff from the four family services agencies that had contracted with the state to provide family reunification services. After the review team agreed that the family met the guidelines for participating in the program, the family was assigned to one of the agencies' family reunion specialists. The specialist met with the family to conduct an assessment and set goals. During the time the family was in the program, the specialist worked with the DFS worker on a regular basis to ensure coordination between the two organizations.

### Case Manager Goals

As part of the referral process, DFS case managers listed their goals for the family. Not surprisingly, the most frequently listed case manager goals were closely related to barriers preventing the child's return home. This was especially true for poor parenting skills, ( $X^2=6.4$ ,  $df=1$ ,  $p=.011$ ) and housing ( $X^2=33.64$ ,  $df=1$ ,  $p=.000$ ). However, manager's goals were not related to whether or not a child reentered foster care after FRS.

### Specialists' Approach

Family reunification specialists had at least a bachelor's degree in social work or a related area, and most had experience in family preservation services. They were trained using a modified Homebuilders™ curriculum, which had been changed to include increased emphasis on safety and separation and attachment issues. Specialists were enthusiastic about the program. They believed they were making progress with the most difficult families seen by DFS.

To find out more about how the specialists saw their role in the program, they were interviewed by the evaluation team 6 to 12 months after FRS started.

**Initial problems:** Initially, specialists were concerned because they spent a great deal of time on housing and other concrete services instead of therapy. They believed safety was an issue in some cases and wanted to be able to accept cases when the safety of a child could be ensured. However, the primary problem facing specialists was inappropriate referrals. They believed workers didn't understand the program or their families well enough to make

the kinds of referrals that could be successful—those families who were interested in making some change.

In response to these concerns, a number of changes were made by the case managers and specialists after the beginning of the program. Specialists became more flexible, lowered their expectations, and built necessary networks of referral sources. DFS case managers became more willing to work with specialists and to trust specialists to work "outside the box." In fact, trust was a major issue at the beginning of the project at both sites. In Jackson County, where specialists met often with court representatives, specialists felt their opinions about families were ignored when decisions were made. As these issues became apparent, relationships with the court and with DFS workers improved.

Because poor communication often contributed to the other problems, several modifications were made to improve the exchange of information. Specialists and DFS workers began to meet on a regular basis to work with the family, and the specialists' supervisors were placed on the screening team. The latter resulted in more appropriate referrals. These changes improved the coordination of services and also increased the mutual trust between DFS workers and FRS specialists.

**Successful cases:** Specialists felt they were most successful with families who wanted to change, where goals were well-defined, where DFS continued to provide support, and where they could provide something different from therapy. They emphasized that families should have already begun visitation with their child and should have sought treatment for substance abuse, if indicated, before starting FRS. As one specialist said, "we work better with cases that are from the middle of the barrel."

Specialists believed FRS was somewhat easier than family preservation services because children were out of the home and not at risk or in crisis when services started. They could concentrate on providing services, because the safety of the child was less likely to be a problem. They were committed to helping families and were excited about their successes, particularly as they believed they were working with a group for whom success has been elusive.

### Specialist Activities

In addition to participating in interviews with the evaluator and administering evaluation instruments, FRS specialists were also asked to keep track of the services they provided each week. To do this, specialists were asked to complete a three-page form that listed all the activities that might be included under clinical and concrete services. Clinical services



were divided into child management, emotion management, interpersonal skills, advocacy, and miscellaneous clinical categories. In all, there were 78 possible services listed.

Specialists were asked to indicate for each week, those ten services they used most often, starting with the service used most often (1) and ending with that used least often (10). While there were changes from week to week, listening or active listening were listed as one of the three most frequently used services every week of the ten weeks that were tracked. During the first four weeks, specialists concentrated on establishing treatment goals and relationship building. In week four, referral to counseling appears as one of the most frequent services offered. After that, specialists are likely to spend more time on concrete services, such as housing and transportation.

Another way to look at specialists' activities is to examine the average use of activities during 10 weeks. Because there were fewer cases open during the end of the period, the scores for each week were weighted to prevent the activities in the later weeks from receiving higher averages.

Table 3 lists those activities used with more than 20% of the families at least once during the 10-week period. As can be seen, a combination of clinical (i.e., providing support and hope and listening) and concrete (i.e., transportation) services are used throughout the intervention. Building self-esteem and handling frustration also remain relatively high throughout the service period. As would be expected, setting treatment goals was high during the first two weeks. Although it's a somewhat crude measure of comparison, an average score for all 10 weeks shows that in their work with families, specialists use listening, transportation, and support most frequently.

### Specialist Goals

As was true for DFS case managers, the specialists' goals closely matched the barriers to the children's return home, particularly in the areas of parenting skills, stress reduction, and family communication, the three most frequently used goals. Using one child in each family, we found therapy (which included improving communication and substance abuse treatment) was more likely to be a specialist goal for families who had a child return to care after FRS, although this relationship only approached statistical significance ( $X^2=5.28$ ,  $df=2$ ,  $p=.07$ ). And, although not statistically significant, children who returned to care were more likely to come from families where the specialist's goals were not achieved.

### Areas of Intervention

In most cases, those areas described as barriers to the child's return home and those areas where specialists intervened were similar. Stress, one of the most frequently mentioned areas of intervention, was likely to be related to the specialist goals of individual therapy or problem-solving. When the areas of intervention used most often by specialists—communication, poor parenting skills, housing, and parent-child conflict—were included in a discriminant analysis, these areas were able to significantly differentiate ( $X^2=12.80$ ,  $df=4$ ,  $p=.01$ ) between the children who remained home and those who returned to care. Children who lived in families where the specialist worked on communication, poor parenting skills and parent-child conflict were more likely to remain home after FRS. When the areas of intervention were combined with the times a child was placed previously, the child's race, and the child's age, the areas of intervention contributed less to the difference between the groups although the combination still significantly differentiated among the groups ( $X^2=23.97$ ,  $df=6$ ,  $p=.001$ ). Children who had fewer placements, were younger, were black, and had specialists who intervened in the area of parenting skills were more likely to remain home.

Although not statistically significant, those children who returned to care were more likely to come from families where the areas of intervention included parent-child conflict and where the child was described as unmanageable. They were also more likely to live in families where physical abuse was described as a barrier to return home and where housing was an issue.

### When Returned to Care

There appeared to be no pattern of when children returned to care with half of the children who returned to care, returning within 167 days.

### Family Well-Being

We used the Walmyr Index of Parental Attitudes (IPA) and Index of Family Relations (IFR) to examine family relationships. The specialists administered the forms to family members early in the FRS intervention and then shortly before termination. Both forms have a clinical cut-off score of 30, with those scoring higher than 30 having a problem in that area. Because the forms ask parents the extent to which they agree or disagree with statements on how they feel about their children and families, it is possible that parents put what they believed was the acceptable answer rather than the way they felt. Specialists were trained to emphasize that there were no right or wrong answers and used a code for the parent's name.



**Table 3. Services Used During 10 Weeks of Family Reunion Services (%)**

Week	1	2	3	4	5	6	7	8	9	10	Σ
Clinical Services											
Support/Understanding	20	15	12	22	8	24	18	22	8	25	17
"I" Statements	2	10	12	10	14	12	23	19	12	10	11
Active Listening	18	20	28	26	24	14	30	24	12	20	22
Time Out	10	13	18	12	6	20	5	12	8	5	11
Natural/Logical Consequences	10	23	20	24	6	18	7	14	0	0	12
Emotion Management											
Building Self-Esteem	24	32	20	24	18	20	30	26	36	30	26
Handling Frustration	28	27	32	30	28	22	30	22	16	35	27
Interpersonal Skills											
Problem Solving	28	27	24	22	20	16	14	28	20	15	21
Advocacy											
Social Services	24	8	14	12	12	8	9	17	8	10	12
Miscellaneous Clinical											
Relationship Building	36	36	28	16	18	16	16	14	12	15	21
Clarifying Family Roles	26	21	24	12	18	10	7	10	4	5	14
Family Rules	16	27	24	10	12	12	9	10	4	5	13
Treatment Goals	52	36	16	14	14	8	5	17	4	10	18
Support/Hope	38	46	46	28	32	40	37	36	28	35	37
Providing Literature	16	13	26	16	8	20	16	12	12	0	14
Listening	56	49	44	40	40	46	44	36	36	40	43
Concrete Services											
Transportation	26	34	44	44	30	44	38	43	36	30	37
Household Goods/Furniture	6	23	12	10	12	14	9	22	12	30	14

The first IPA was completed by 54 people, with 49 scoring below 30 and 5 scoring above. The follow-up IPA was completed by 25 people. Of those who scored above 30 originally, 2 had follow-up scores below 30, one still had a score above 30 and two did not have

follow-up scores. Fifty-three people completed the IFR the first time, with 35 scoring below 30 and 8 scoring above. When the IFR was repeated, 29 people completed the scale with 4 still scoring above 30. Because the number of parents for whom we have completed forms is so small, it is difficult to make any assumptions about the relationship between these scores, the specialist's activities and a child's reentry into care, but at this point, there appears to be little correlation between the two.

Because specialists were asked to indicate if a family refused to participate, and few did, the low completion rate is more likely to reflect the fact that the specialists placed a low priority on the evaluation when they had a limited amount of time to work with families. In fact, one questionnaire was discontinued because specialists felt it took too long to administer.

### Child Self-Esteem

Children over 10 were asked to complete the Piers-Harris. Only 17 completed questionnaires were available for analysis with 12 of those scoring in the 7th stanine or above. The children who returned to care (4) scored in the 6th stanine or below, but the numbers are so small, it is difficult to make any assumptions about the relationship between a child's self esteem and the success of FRS.

### Interviews with Clients

Interviews were held with 10 randomly selected FRS clients, and a follow-up survey was sent to families from Jackson County by DFS. Of the families visited, one had a child remain in care, another had a child return to care. Attempts were made to visit several other families, but they either were not at home at the time of the appointment or did not respond to a request to interview them. Many parents didn't have phones or had moved by the time we tried to contact them. Because information is from a small number of reachable parents, the information may not reflect the thoughts of all FRS families.

The interviews and surveys indicated families were pleased with the program, even those families where children either remained in care or returned to care. In those families, parents understood that either they or their child had problems that would make it difficult for their child to live with them, and they were comfortable with the arrangements made for their child.

Families liked FRS because specialists were available to them and knew them. "More intense" was the phrase used most often to describe the difference between FRS and traditional services. Parents said they were able to understand their children's behavior



better and were taught how to relate actions to consequences. Parents also learned how to structure time and set limits.

Skills learned during FRS were used after the specialist terminated, but most of the parents said they could have used more follow-up and additional services. Several parents wanted information on how to apply skills they learned as their child got older. Families continued to need services after FRS. Housing, transportation, and family counseling were those most requested. Although it was not a question asked, it does appear that FRS clients had more of a family focus after receiving the services. That is, they are more able to understand how they function as a unit rather than as individuals living in the same house.

### Limitations of Study

Initially we believed that specialists would be able to use the Walmyr IPA and IFR in their work with clients. It soon became apparent that the collection of research information was low on their list of priorities, and data were missing for more than half of the families. It is not clear how those families for which we have completed instruments differ from those for whom the instruments are missing. We have been cautious in interpreting these data. Data were also missing from some records at the time of review. Attempts were made to return to records that had missing data, but in some cases, the FRS case was completed before the missing data were added. This was true in the case of some specialist goals and some specialist activities forms. On the other hand, specialists provided information on areas of intervention to the state database, and these data were used whenever possible.

Records from one of the sites were complete, while records from the other site had more missing data. Because there was no difference between the sites on the number of children returning to care and the specialists received the same training and had the same resources, we assume that information on specialists' activities are generalizable from site to site. However, because the sites are both large cities, it is not clear how the process described here will generalize to smaller cities and rural areas. The majority of the children in this study were African-American, and it is also not clear how these findings will apply to other groups.

### Discussion

Although FRS appeared to meet some initial resistance from DFS workers, changes made during the 18 months the project was being followed improved the workers' willingness to refer to the program. Lines of communication, and therefore trust, improved and more appropriate referrals were made.

Specialists engaged in a range of behaviors, but much of their time was spent listening to clients or on concrete services like housing and transportation. Specialists did not see themselves as therapists and emphasized that their role was to supplement therapy. In fact, therapy was the service being used most often by parents when they began FRS. But, those children who returned to care were more likely to have therapy as a goal. If we assume that those are the families who had not yet started therapy, it would suggest that specialists are correct when they define themselves as providing services in addition to therapy. It also implies that FRS works best if families have been in therapy prior to referral to FRS. Specialists can be more effective in changing behaviors if parents are working on understanding themselves and their families. And families may be more amenable to change if they have already begun the therapy process.

The use of services also underscores the ways in which specialists differ from therapists and, to some extent, DFS workers. The specialists spend most of their time listening, providing support or transporting clients. At first, specialists were concerned because they spent so much time transporting parents. They soon learned that they could do some of their best listening and intervention in the car and in waiting rooms. On the other hand, DFS case managers, who have much larger caseloads, need to focus on obtaining services for clients.

Overall, specialists liked FRS because they felt they were accomplishing changes that otherwise would not occur. They believed it was less stressful than family preservation services, because children were out of the home and not at risk when intervention began. This allowed them to focus on the family interaction.

Families appeared to be pleased with the services they received. They appreciated the specialists' concern and willingness to advocate for them. They often expressed regret that the specialist could not continue working with them after FRS ended. Several families believed that even though the outcome was not what they originally hoped for (the return of their child), the outcome was the best for everyone.

### Summary

The use of intensive family preservation services to reunite families who otherwise would be unlikely to reunify can be considered successful when compared to other studies (Fein & Staff, 1991; Fraser, Walton, Lewis, Pecora & Walton, 1996) and to DFS' traditional foster care. Children accepted into FRS are children who, when compared to children in traditional alternative care, have experienced significantly more placements in the 16 months prior to FRS and have fewer reentries in the 16 months after exit from FRS.



When the FRS children who subsequently re-entered care were compared with those who didn't, children who remained home had fewer prior placements, were younger, were black, and were more likely to have specialists intervene in the areas of parenting skills and communication problems. Successful families are those where changes within the family environment (e.g., communication, improved parenting skills) occur. Specialists' activities suggest they are most effective providing services that supplement therapy and that they are able to provide a unique combination of clinical and concrete services that, when achieved, contribute to children remaining home.

These findings indicate that intensive services work not only when families are in crisis, but also when traditional approaches don't. Specialists who spend several hours a day with families are able to quickly identify problems in communication, and in the use of discipline and other parenting skills. By modeling new behaviors and encouraging parents, they are able to help parents change behaviors, or when change doesn't occur, to help parents support other permanency plans. Moving quickly to other permanency plans has become even more important since the passage of the Adoption and Safe Families Act.

FRS is less successful with families where housing is an issue and who have children with behavior problems. Housing should not prevent the permanent reunification of families. It makes little sense for children to remain in the foster care system for long periods of time because housing is unavailable. Although this may be more of a problem for urban families than for others, it does indicate that the foster care system must be able to provide a range of concrete services for families. In most cases this is done, but these findings suggest there should be closer links between child protective services and local housing authorities.

This study also suggests that when a child has been described as unmanageable, intensive clinical services must be used early on to supplement the work of the specialist. If substance abuse is a problem, parents must receive treatment before participating in FRS. It follows that a child who exhibits severe behavior problems and his or her family should receive therapy and show improvement before they are accepted for FRS.

Although this study found that parents who have at least started therapy are more amenable to treatment and more likely to respond to family reunification, the number of placements prior to FRS appears to contribute the most to children returning to care. It is important to consider the use of FRS or other family preservation programs earlier in a child's alternative care career as a positive step toward preventing additional placements.

One of the difficulties we continue to have is predicting which families can benefit most from FRS services, although it does appear that for the majority of families judged unlikely

to reunify with their child in the near future, FRS provides the extra support needed for reunification. However, there is a need for studies that follow families over time and more closely examine the interaction between family problems and the use of services. Additional studies will help determine more specifically which services are most appropriate for which families. This will allow us to be more responsive to the requirements of the Adoption and Safe Families Act.

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## A Multi-Dimensional Approach to Evaluating Family Preservation Programs

**Cynthia A. Ford and Felix A. Okojie**

*The current study evaluates the effectiveness of family preservation programs funded by the Mississippi Department of Human Services. This venture encompassed scrutiny and assessment of improvements in child functioning, positive changes in parental functioning and family functioning and the decrease in foster care placement. Further, this evaluation assessed client and staff satisfaction. It also included an assessment of the perceived impact this program had on the community. Results indicate that the family preservation programs were effective in improving the self-esteem of participants, family cohesion, and adaptability. There were no significant changes in child placement, teen births, or abuse rates. Client and staff satisfaction were high on all quality dimensions. The majority of the sample of community members felt that the family preservation programs were effective in the community.*

Community-Based Family Preservation/Family Support Services emerged as an innovative strategy for strengthening families, preventing out-of-home placement of children, and for reuniting children with their families. The genesis of family- and home-based services and family preservation services can be traced to the concern that traditional child welfare services were failing to meet the needs of children and their families in the United States. During the 1960s and 1970s, the field of child welfare was castigated because it was believed that children were being placed in substitute care who could have remained at home. Of paramount concern was the inordinate number of placements for ethnic minority families.

During the 1960s and mid-1970s, new program models preventing foster care placement began to emerge, many of which used the cognitive-behavioral and/or family therapy treatment techniques that were being developed during the time (Pecora, 1991). During the early 1970s, a number of child welfare agencies were also successful in preventing child placement through family-focused counseling (Hirsch, Gailey, & Schmerl, 1976) or through the use of a variety of emergency services, such as crisis counselors, homemakers, emergency shelters or foster homes, and emergency caretakers (Burt & Balyeat, 1974; National Center for Comprehensive Emergency Services to Children, 1978). These



programs recognized the importance of crisis intervention in the prevention of long-term foster care placement.

The Federal Adoption Assistance and Child Welfare Act of 1980 mandated that states strengthen and preserve family life by making "reasonable efforts" to prevent out-of-home placement of children and to allow the return of placed children to their families. As time progressed, there was an increase in the number of family-based services, home-based services, and family preservation service programs (FP/FSS) on a statewide basis in a number of states, such as Florida, Illinois, Maryland, Michigan, Minnesota, and Tennessee (Grohoski, 1990; Holliday & Cronin, 1990). Such programs were a manifestation of the commitment made by the state and local governments to preserve families. In 1988, the National Resource Center on Family-Based Services published an annotated bibliography of 333 "family-based" programs in over 25 states. These programs provided services that were alternatives to out-of-home placement by ameliorating family functioning as well as by linking families to sustaining services and sources of support.

As a result of the Family Preservation and Support Services Act of 1993, each state is responsible for developing a Child and Family Service Plan (CFS) by which local communities will plan, implement, and evaluate effective family support/family preservation programs and services. Pecora (1991) notes that attendant to the increase in family preservation programs and the claims of effectiveness are a variety of questions that agency administrators and policy makers have begun to pose: (1) What specific services are we funding? (2) How effective are these services in relation to improving child/family functioning and preventing foster care placement? (3) Can the use of family-based services, home-based services, and family preservation programs services save child welfare program funds?

Responding to these questions has been difficult. Much of this difficulty is due to the tremendous variation of the service characteristics of the programs under the nomenclature of family preservation service programs. Several studies over the years have attempted to address these questions. Below is a review of some of the research endeavors undertaken to assess the impact of FP/FSS.

In an evaluation of a sample of 74 families after 10 months, Nelson (1984) found substantive difference although no statistically significant difference in placement preventive rates between treatment (77%) and control groups (55%) existed. Yuan, McDonald, Wheeler, Struckman, Johnson, & Rivest, (1990) studied home-based and family preservation programs in California. A sample of families was followed for eight months after case referral. Results indicated that 80% avoided placement. However, when a

comparison was made later in this study between the home-based service group and a comparison group, there was no significant difference. The disparity in findings was due to the fact that the treatment group families delayed their placement episodes longer, used a higher proportion of shelter care placements, and used 1500 fewer days of placement than the comparison group cases (Yuan, et al., 1990). Other studies using experimental or quasi-experimental designs demonstrate similar results (Rosenberg, et. al., 1982; Willems & DeRubeis, 1981; Szykula & Fleischman, 1985).

One of the first rigorous studies of early FP/FSS was conducted in Hennepin County, Minnesota. In this study, 8.6 % of the comparison group remained with their families, compared to 43.6% of the children in the treatment group. (Personal communication with P. AuClaire as noted in Pecora, 1991). Feldman (1990) evaluated a MFP/FSS in New Jersey and found the placement prevention rate for the treatment group to be significantly lower than that of the control group after 30 days, 60 days, 90 days, 3 months, and 9 months post-termination, although there was no significant difference in the placement prevention rate at termination (92.7% for the treatment group as compared to the control group 85.1%). This study also investigated changes in child/family functioning. Both groups made similar gains on measures of family functioning, but the treatment group scored significantly higher on the Child Well-Being Scales.

Even though family preservation programs have been effective in reducing placement rates, as note earlier, social conditions have generally declined. Meezan & McCroskey (1996) and Pecora (1991) state that one of the concerns of many family-based practitioners and researchers has been overemphasis of the field upon placement prevention, rather than considering additional types of outcomes, such as the following: (1) improvement in child functioning (e.g., behavior, school attendance, school performance, self-esteem); (2) positive changes in parental functioning (e.g., depression, employment, substance abuse, anger management, self-esteem, parental skills); (3) Improvements in family functioning (e.g., family conflict, communication, cohesion, adaptability, or social support; and (4) Use of child placement as a stabilizing influence and means for family reunification, or use of FP/FSS to stabilize a foster home as permanent placement for children who should not return home. Berry (1992) also notes that evaluations of intensive family preservation programs have primarily involved reporting of placement prevention rates, which have ranged between 75 percent and 90 percent (e.g., Pecora, Fraser, Haapala, & Bartlome', 1987; Reid, Kagan, & Schlosberg, 1988). Berry further believes that other relevant criteria have not been adequately addressed, such as elements of intensive family preservation programs that contribute to the success of such programs. In her evaluation of a family preservation program in northern California, Berry (1992) examined the specific service elements of the program, the match of family services to family needs, and gains in parental



skills. She found that the demographic characteristics of the preserved families and those experiencing placement were not substantially different; time spent with the family was not significantly different for preserved families when compared to those experiencing placement. The type of service provided made a difference in treatment success; there were significant gains in parent skills among intact families in comparison to those experiencing placement. Specific services, such as teaching family care, counseling, help in securing food and financial services were significantly associated with gains in parent skills. Grack (1997) also believes that family preservation services have focused immensely on outcomes. However, an understanding of the processes of family is crucial to effective practice. Grack (1997) further notes that few family preservation evaluations have shown which service components, characteristics, and compositions have engendered positive outcomes for families.

The purpose of this evaluation was to ascertain the effectiveness of Mississippi Family Preservation/Family Support Services (MMFP/FSS) Programs funded by the Mississippi Department of Human Services. While it is important to determine program effectiveness, it is also important to determine whether variations in such programs influence effectiveness, how effective such programs are in a variety of communities, and how effectiveness varies by characteristics of clients. This venture encompassed scrutiny and assessment of improvements in child functioning, positive changes in parental and family functioning, and the decrease in foster care placement. Further, this evaluation assessed client and staff satisfaction. This evaluation distinguished itself from previous evaluations of this nature in that an assessment of the impact this program had on the community and the community's perception of these programs was conducted. This distinction was further enhanced by the additional attempt to ascertain which intervention strategy was most effective and whether the effectiveness of these strategies varied by characteristics of the clients. More specifically, this evaluation addressed the following questions:

- To what extent does participation in the MFP/FSS influence the well-being of families and the safety of children over time?
- What service strategies have the greatest impact on family well being and child safety?
- How and to what extent have collaborative service systems been established or enhanced through family preservation and family support?
- What is the extent of client satisfaction or perception of program and programmatic activities?

- Are the stated goals and objectives being met?
- What is the extent of staff satisfaction?
- What impact do the MMFP/FSS have on the community?
- How does program effectiveness vary by characteristics of clients.

This paper is a summary of the findings resulting from endeavors to address the foregoing questions.

### **The Mississippi Family Preservation/Family Support Services**

The Mississippi Family Preservation/Family Support Services were designed to (1) protect children from abuse and neglect; (2) strengthen families and communities in a manner that will contribute to a healthy and safe environment for all children; and (3) expand a continuum of services for family and children to promote and support family-building. While there are distinctions between family preservation and family support services, the MMFP/FSS comprise a continuum of services that aids families in either avoiding problems or dealing with problems early by forming community-based partnerships in support of families. More explicitly, of the dual nature of MMFP/FSS (both a family preservation and family support program), the following common characteristics existed (1) services were designed from a culturally competent delivery system; (2) services were client driven; (3) services build on client strengths; (services are delivered outside the office, either in the home or the community); services rendered are those rendered by both family preservation and family support programs (e.g., home visits, child development, parenting skills, support groups etc.); and services stress flexibility and creativity (Mississippi Department of Human Services, 1995). The MMFP/FSS consisted of 18 programs located throughout the state. The services rendered in the various programs were primarily comprehensive (e.g., counseling, parenting skills, management skills, early childhood development education, day care, job training, care taking skills, after school program, working with student truants, working with teens, tutorial, health care, crisis intervention). Although the types of services varied, most included a combination of the foregoing services. However, there was a common thread that ran through all the programs and that was education—education of clients, professionals working with the families, and the community at large.



## Method

### Description of Sample

Two hundred and thirty seven (237) clients were randomly selected from the total (1691) population. The population consisted of referrals from the Mississippi Department of Human Services (DHS), the State (Mississippi) Health Department, hospitals and schools, and court. Demographic data were collected on each client at intake. The sample consisted of clients from 12 sites in the state of Mississippi. Over sixty-one percent (61.8%) were African American and 38.2% were white. The majority (62.5%) were single parents, 18.3% were married, 17.4% were divorced, and 1.8% were widowed. Clients were currently enrolled or had completed the following educational levels: 48.2% high school; 32.7% college; 17.3% junior high school; and 1.8% elementary school. Some (5.6%) of the clients had no children; 36.7% had one child; 26.7% had 2 children; 16.7% had 3 children; 7.8% had 4 children; and 1.1% had 6 children. The reason for referral for the majority of clients was parenting, counseling, or GED preparation. See Figures 1-6 for a pictorial presentation of the demographics.

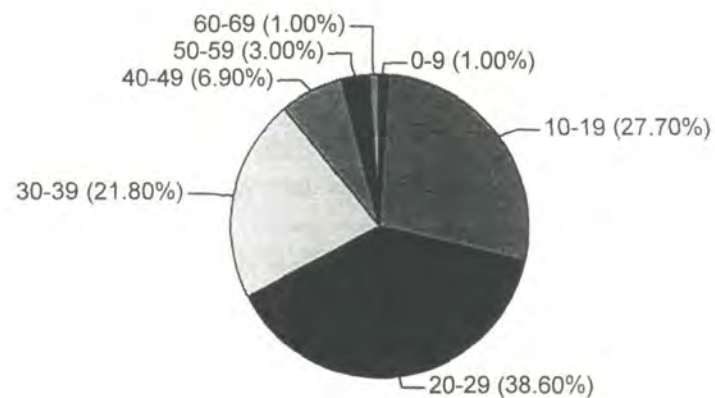


Figure 1. Age Distribution of Sample



Figure 2. Racial Composition of Sample

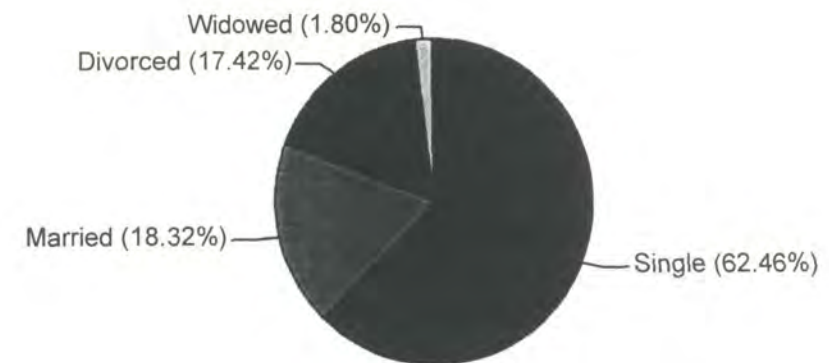


Figure 3. Marital Status of Sample



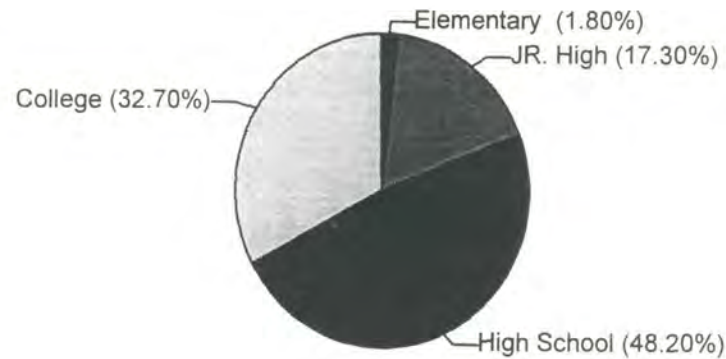


Figure 4. Educational Level of Sample

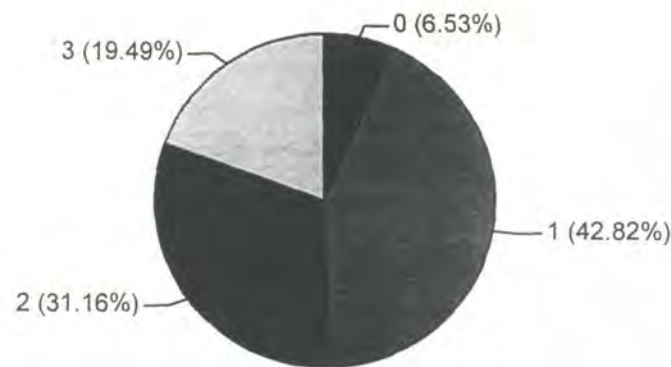


Figure 5. Clients' Number of Children

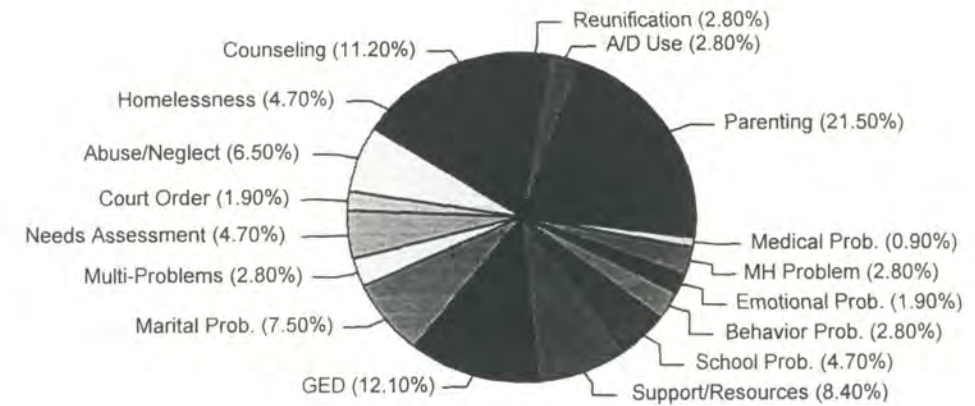


Figure 6. Reason for Referral

### Research Design

Although the programs under the MMFP/FSS were both family preservation and family support programs, there were many similarities noted previously in this report. It is because of these similarities that aggregate analyses of the data were conducted. To identify changes in child and family functioning, a quasi-experimental design (one-group pre-test-post-test) was employed. Data were collected at intake and at termination. Descriptive statistics were employed to ascertain *n*, the extent of client and staff satisfaction regarding specific dimensions of service quality that Zeithaml, Parasuraman & Berry (1990) found to be important to clients of human service programs. Descriptive statistics were also employed to determine the community perception of the MMFP/FSS. To determine the extent to which participation in the MMFP/FSS influenced the well-being of families and the safety of children over time, statistics on abuse, teen pregnancy, and foster care placements were analyzed for counties in Mississippi in which MMFP/FSS programs existed. ANOVA was also used to determine if there were significant differences in means for abuse, teen births, and foster care placements over the months in which the programs existed. The evaluators expected gradual reductions in abuse, teen births, and foster care placements as the months progressed. Therefore, tests of linearity were conducted to determine whether there were significant linear trends in the incidences of foster care placements, live births to teens, and child abuse in the counties in which the MMFP/FSS existed and over the time span in which the programs existed. To determine whether MMFP/FSS participation affects family



functioning and perceived availability of resources, T-tests were conducted on pretest and post-test subscale scores and composite scores of FACES and ISEL to determine whether significant differences existed between pre-test and post-test scores. Regression analyses was also conducted to determine whether selected variables( age of client, county of client, number of children, client satisfaction (composite score), education, marital status, race, site, staff satisfaction, type of and intervention strategy used) contributed significantly to variations in subscale and composite scores of FACES and ISEL. Regression analyses were also conducted to determine whether intervention strategies accounted for a significant amount of variance in measures of program effectiveness (e.g., family functioning) and to determine whether effectiveness varies by characteristics of the clients.

### Measures

**Interpersonal Support Evaluation List (ISEL)** was used to assess the perceived availability of the four separate functions of potential social resources as well as providing an overall functional support measure. The items that comprise the ISEL fall into four 10-item subscales: (1) The "tangible" subscale is intended to measure perceived availability of material aid; (2) The "appraisal" subscale is the measure of perceived availability of someone to talk to about one's problems; (3) The "self-esteem" subscale measures the perceived availability of a positive comparison when comparing oneself with others; and (4) The "belonging" subscale measures the perceived availability of people one can do things with. This instrument was administered at intake and termination.

**The Family Adaptability & Cohesion Evaluation Scales (FACES III)** is the third version of FACES scales developed to assess the two major dimensions in the Circumplex Model, i.e., family cohesion and family adaptability. Family cohesion refers to the degree to which the family is connected. Family adaptability refers to the degree to which the family is flexible to make change. The Circumplex Model enables an individual to classify families into 16 specific types or three more general types, i.e., balanced, mid-range, and extreme. Further, it is designed to obtain both perceived and ideal family functioning. This instrument was administered at intake and termination.

**Client Satisfaction Questionnaire.** Client satisfaction was assessed by adapting items from Martin 1993. Client satisfaction was used to measure clients' perceptions of the services they received and as an outcome performance measure, which involved clients self-report of quality of life changes. Zeithaml, Parasuraman, & Berry (1990) found that a common set of quality dimensions were important to clients of human service programs regardless of the type of service provided. Several quality dimensions were found to be important. In rank order, the preferred set of quality dimensions were reliability, responsiveness, assurance,

empathy, and tangibles. The foregoing quality dimensions along with others identified by Martin (1993) were used to determine client satisfaction.

Table 1 provides a list and description of each dimension of quality assessed in this study. The questions used to assess client satisfaction were designed by the evaluators and were based on the quality dimensions listed in Table 1. The questions and responses are noted in Table 12.

**Table 1. Quality Dimensions Assessed on Client and Staff Satisfaction Questionnaire**

Dimension	Definition
Accessibility	The program is easy to access or acquire.
Assurance	The program staff are friendly, polite, considerate, and knowledgeable.
Communication	Program information is provided in simple, understandable language.
Competency	Program staff possess the requisite knowledge and skills.
Conformity	The service meets established standards.
Courtesy	Program staff demonstrates respect toward clients.
Deficiency	The program is missing a characteristic or element.
Durability	The program's performance or results do not dissipate quickly.
Empathy	Program staff attempt to understand clients' needs and provide individualized attention.
Humaneness	The program is provided in a manner that protects the clients' sense of self-worth & dignity.
Performance	The program accomplished its intended purpose.
Reliability	The program is operated in a dependable and reliable manner with minimum variation.
Responsiveness	The program delivery is timely.
Security	The program is provided in a safe setting free from risks or danger.
Tangibles	The appearance of the facilities, equipment, personnel, and published materials is appropriate.

SOURCE: Adapted from Martin (1993)



**Staff Satisfaction.** Tangentially, the same dimensions were used in the assessment of staff satisfaction. Some of the same questions were posed to the staff in an endeavor to assess staff satisfaction with the program and perceived impact of the program on clients. Staff members were also asked about their perception of the impact of the program.

**Collaborative Systems on MFP/FSS.** Additionally, staff were asked questions regarding the community resources used, where referrals were directed, and were the referrals part of a collaborative community service system? This information provides a more comprehensive picture of the extent to which collaborative service systems have enhanced MFP/FSS programs.

**Perceived Community Impact.** The evaluators also designed a short questionnaire which was administered to community members to determine the community's perception of the impact of MFP/FSS Programs on their community. Table 14 provides the questions and percentages of responses.

### Results

T-tests of pretest and post-test subscale and composite scores were conducted to determine whether significant differences existed in scores on measures of family functioning and functional support. Results indicated that significant differences between pretest and post-test scores did exist for 3 subscales scores of the ISEL (Tangible, Appraisal and Self-Esteem subscales) and composite score for the ISEL. Table 2 shows that means were significantly higher for the foregoing scores after participation in the MMFP/FSS Program. Composite ISEL scores indicate that clients perceived an increase in the availability of social resources. More specifically, subscale scores indicate that clients perceived an increment in the availability of material aids and perceived an increase in the availability of a positive comparison when comparing oneself with others after participation in the program.

**Table 2. T-test on Pretest and Post-test Subscale and Composite Scores of ISEL**

Subscales	No. Of Pairs	Mean	t-value	df	Significance
Tangible 1 Tangible 2	74	15.90 17.31	-3.09	73	.003*
Appraisal 1 Appraisal 2	74	16.97 19.54	-6.47	73	.000*

Subscales	No. Of Pairs	Mean	t-value	df	Significance
Self-Esteem 1 Self-Esteem 2	96	17.30 22.25	-13.13	95	.000*
Belonging 1 Belonging 2	74	17.40 18.12	-1.36	73	.177
Composite ISEL 1 Composite ISEL 2	74	67.46 77.47	-8.05	73	.000*

\*Significant (alpha level=.05)

As noted in Table 3, results further showed that significant differences between pretest and post-test scores did exist for 2 subscales of FACES (Cohesion and Adaptability). Mean pre-test scores of the two subscales indicated that the average scores on adaptability and cohesion fall under the nomenclature of flexibly disengaged. While post-test mean scores fall under the nomenclature of flexibly separated. These means indicate the average family was classified as flexibly disengaged at intake. After participation in the program, the average family was classified as flexibly separated. This modification indicates that the family changed from being disinclined to talking to amenable to talking among themselves to resolve their problems.

**Table 3. T-test on Pretest and Post-test Subscale and Composite Scores of FACES**

Subscale	No. Of Pairs	Mean	t-value	df	Significance
Cohesion 1 Cohesion 2	87	34.49 36.97	-4.56	86	.000*
Adaptability 1 Adaptability 2	87	26.77 25.45	2.20	86	.030*
Total FACES 1 Total FACES 2	87	61.25 62.42	-1.43	86	.156

\*Significant (alpha level=.05)



Stepwise Regression analysis was conducted on score differences in pretest and post-test on subscale and composite scores (only those that were found to be significantly different) of the ISEL and FACES to determine whether demographic characteristics of clients (age, number of children, education, marital status, race, county in which the clients live) as well as site of the program in which client participated, overall staff satisfaction with the program, and the type of intervention strategy used contributed significantly to differences between pretest and post-test subscale and composite scores for the ISEL and FACES. The variables of interest contributed significantly to differences on pretest and post-test scores of only 2 subscales: Self Esteem and Cohesion. Table 4 is a summary of the stepwise regression analysis. Age of clients and the type of intervention used accounted for 33.6% of the variance in pretest and post-test Self-Esteem subtest score differences. The age of the clients accounted for 27.3% of the variance and the type of intervention accounted for 6.3% of the variance in pre- and post-test differences.

**Table 4. Regression Coefficients for Selected Variables on the Differences in Pre-test and Post-test Self-Esteem Subscale Scores**

Variable	Multiple R	Beta	Significance
Age of Client	.5405	.5405	.0007*
Interventions	.6111	.3079	.0464*

\*Significance Multiple R= .6111;  $R^2$ = .3355; n=96

Scrutiny of the means and mean differences indicates that the greatest change in pretest and post-test scores on the self-esteem subscale occurred for clients ages 40-49 as indicated in Table 5. The largest mean change in self-esteem were in clients who received home visits as indicated in Table 6. The second largest change was in clients who received counseling, while the third largest change in self-esteem was in clients who participated in support groups.

**Table 5. Self-Esteem Subscale Pretest , Post-test, and Mean Differences by Age**

Age of Client	Pretest Mean	Post-test Mean	Mean Difference
10-19	15.85	20.75	4.90
20-29	17.65	22.28	4.62
30-39	20.21	24.42	4.21
40-49	16.20	24.00	7.80
50-59	20.00	26.00	6.00

N=96

**Table 6. Self-Esteem Subscale Pretest , Post-test and Mean Differences by Intervention**

Interventions	Pretest Mean	Post-test Mean	Mean Difference
Counseling	16.65	23.30	6.65
GED	18.37	22.72	4.35
Home Visits	15.80	23.00	7.20
Job Skills	18.00	22.50	4.50
Life Skills	21.00	26.00	5.00
Parenting Education	20.78	25.00	4.22
Support Group	17.50	23.50	6.00

N=96

Race accounted for 10.8% of the variance in Cohesion pretest and post-test differences. Table 7 is a tabular explanation of the stepwise regression analysis. Table 8 shows mean differences in pretest and post-test cohesion subscale scores by race. The greatest change in cohesion occurred among whites as indicated in Table 8.

**Table 7. Regression Coefficients for Selected Variables on the Differences in Pre-test and Post-test Cohesion Subscale Scores**

Variable	Multiple R	Beta	Significance
Race	.3759	.3759	.0487*

\*Significance Multiple R= .3759;  $R^2$ = .1082; n=87

**Table 8. Cohesion Subscale Pretest , Post-test and Mean Differences by Race**

Race	Pretest Mean	Post-test Mean	Mean Difference
African Americans	33.71	35.88	2.17
Whites	37.00	40.08	3.08

n=87



As noted earlier, statistics on abuse, teen pregnancy, and foster care placements were analyzed for counties in Mississippi in which MMFP/FSS programs were located to determine the extent to which participation in the MMFP/FSS influenced the well-being of families and the safety of children over time. Means were calculated for the months the programs existed, and tests of linearity were conducted. A list of means by months for the incidences of abuse, teen births, and foster care placements is found in Table 11. Analysis of variance was conducted to determine whether there were significant differences in the means over the time span of interest. Table 9 includes ANOVA results. There was no significant difference between means over the time span. Although there are decrements in abuse, teen births, and foster care placements as the months progressed, these decrements were not statistically significant. Pictorial presentations of the data for the foregoing variables are shown in Figures 7-9.

**Table 9. ANOVA Statistic Results for Abuse, Teen Births and Foster Care Placements**

Variable	F	Significance
Abuse	.2158	.9995
Teen Births	.3988	.9859
Foster Care Placements	.1441	.9983

Tests of linearity for abuse, teen births, and foster care placements were not significant for either variable ( $p=.5652$ ;  $.2274$ ; and  $.3186$  respectively) as noted in Table 10.

**Table 10. Tests of Linearity on Abuse, Teen Births and Foster Care Placements.**

Variable	R Squared	Significance
Abuse	.0006	.5652
Teen Births	.0013	.2274
Foster Care Placements	.0034	.3186

R Square statistics show that less than one percent of the variance in abuse, teen births, or foster care placements can be linearly explained by time (months).

**Table 11: Means on Abuse, Live Births by Teens and Foster Care Placements in counties where MFP/FSS Programs Existed**

Month	Abuse	Births	Placements
January '96	25.06	5.14	
February '96	21.80	4.83	
March '96	23.09	4.50	
April '96	26.16	4.24	28.03
May '96	29.26	4.20	26.16
June '96	21.51	3.77	28.16
July '96	24.16	4.85	28.33
August '96	26.61	5.48	27.83
September '96	24.87	5.09	27.53
October '96	25.09	4.41	-----
November '96	19.00	4.24	-----
December '96	20.45	5.25	-----
January '97	23.03	4.90	-----
February '97	22.67	4.19	22.83
March '97	22.71	4.51	23.03
April '97	24.62	3.54	22.50
May '97	22.36	4.17	22.73



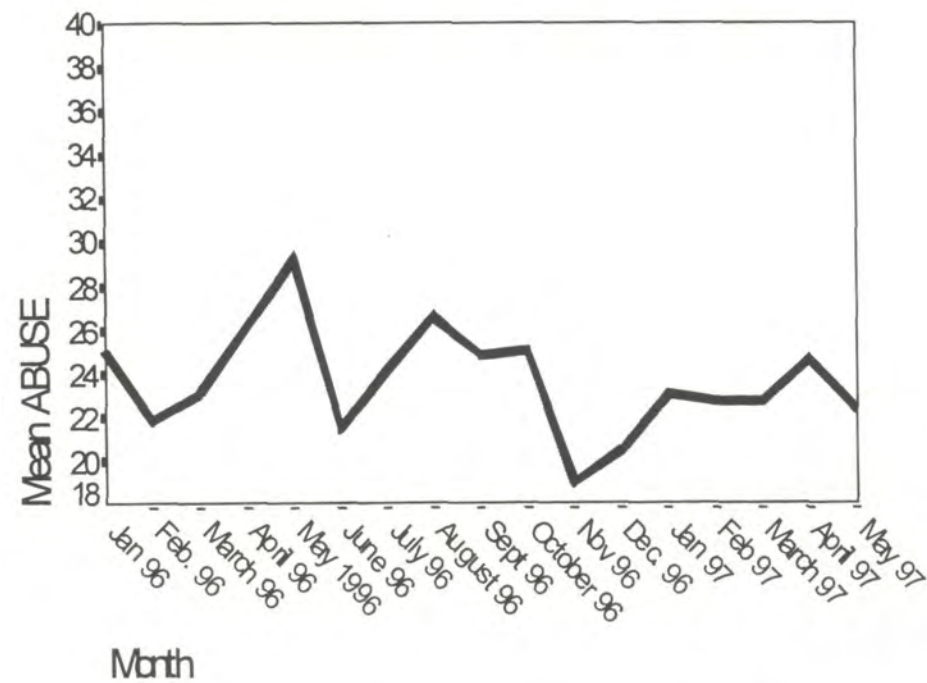


Figure 7. Mean Abuse Rates in MFP/FSS Counties in Mississippi

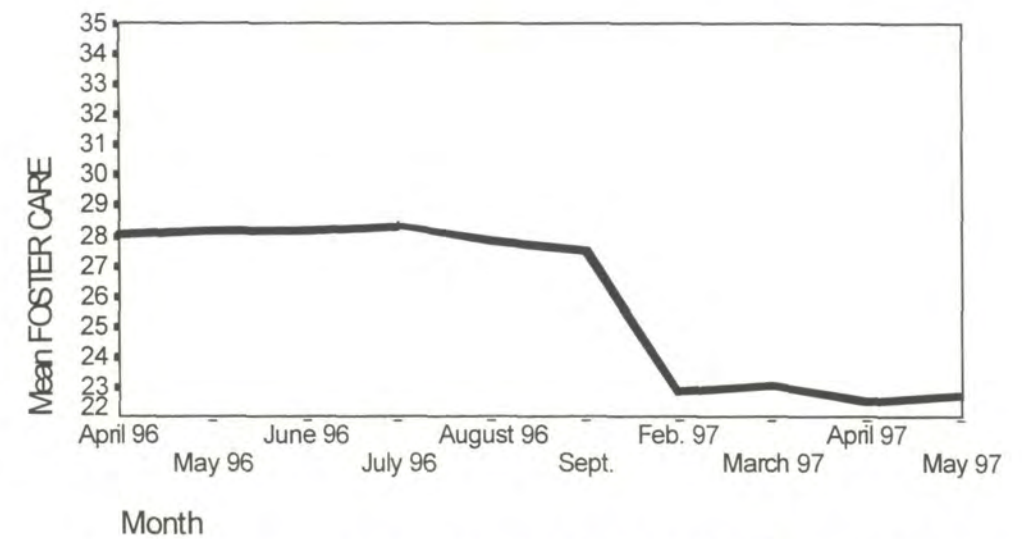


Figure 8. Mean Foster Care Placements by Month in MFP/FSS Counties in Mississippi



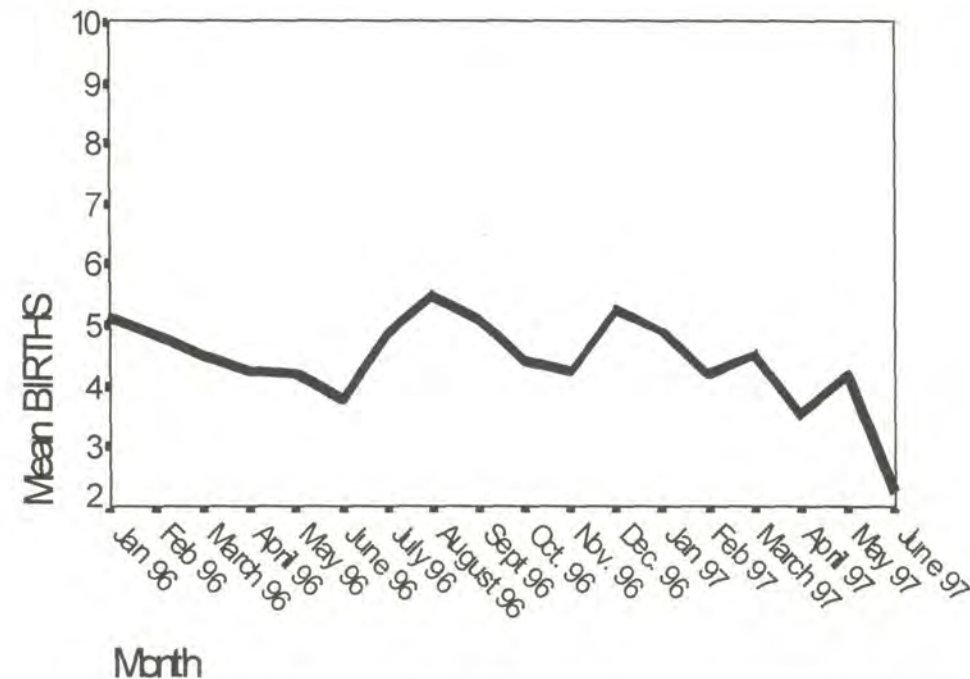


Figure 9. Mean Births to Teens By Months in MFP/FSS Counties

**Client Satisfaction.** The following quality dimensions were assessed: Reliability, Responsiveness, Assurance, Empathy, Tangibles, Access, Communication, Competency, Courtesy, Durability, Humaneness, and Security. Attendant to questions assessing these dimensions were questions that measured clients' overall satisfaction with the programs and outcome performance—the degree to which the client felt the program had helped him/her with his/her problem. In terms of overall satisfaction, approximately (91.7%) reported feeling satisfied to very satisfied with the program. The percentages of the last 2 levels (feeling satisfied to very satisfied) of the likert scale were added together for responses to each dimension. Ratings were high on all dimensions (ranging from 89.1% to 95.3% of clients (n= 238) reporting being satisfied to very satisfied) on each dimension.

**Staff Satisfaction.** The same quality dimensions were assessed on the staff satisfaction questionnaire. Additionally, questions were posed regarding the impact of this program on certain social problems. In terms of overall satisfaction: 86.8 % (n = 93) reported feeling satisfied to very satisfied with the program. The percentages of the last two levels of the Likert Scale were added together for each dimension. Results demonstrated that ratings

were high on all dimensions ranging from 89.2% to 100% on each dimension. These ratings indicate that the staff felt that the program had a positive impact on the community and reduced the prevalence of specific social maladies.

**Collaborative Systems on MFP/FSS:** Staff were asked questions regarding the community resources used, where referrals were directed, and if the referrals were part of a collaborative community service system.

**Resources Used:** Below is the percentage of staff members who used the following resources: the Health Department (13.7%); Mental Health Dept. (Regional) (19.6%); Department of Human Services (17.6%); Community Action Agency (13.7%), Educational Programs (5.9%); Employment Agencies (3.9%); Treatment Centers (3.9%); Shelters (5.9%); Medical Resources (5.9); Housing (3.9); Legal System (2.0%); Community Resources (9.8%).

**Referral to Agencies.** The percentage of staff members who also report making referrals within agencies was 9.3%; outside of agency was 61.1%; and both within and outside of agency 29.6%. This information provides a more comprehensive picture of the extent to which collaborative service systems have enhanced MFP/FSS programs.

**Referral as part of a collaborative community system:** Staff were asked if referrals were part of a collaborative community service system. Approximately (91.7%) percent reported that the referrals made were part of a collaborative community system and 8.3% reported to the contrary.

**Perceived Community Impact:** A questionnaire was also disseminated to members of the community. The results are noted in Table 14. Most (86.6%) felt that the program had been effective to very effective in the community. Most (83.9%) agreed to strongly agreed that the program would have long-term benefits. Most (92.3%) also agreed to strongly agreed that the program had helped to strengthen the families involved. Most (87.3%) also agreed to strongly agreed that the community in general had benefitted from the program.



**Table 12. Percentage of Responses on Community Impact Questionnaire**

1. Overall, how do you rate the effectiveness of this program on the community.	Not Very Effective			Very Effective	
	1	2	3	4	5
	.7	1.4	11.3	31	55.6
2. The information and/or services in this program will have long-term benefits.	Strongly Disagree			Strongly Agree	
	1	2	3	4	5
	.7	1.4	14.1	25.4	58.5
3. The program has helped to increase the strength of families involved.	Strongly Disagree			Strongly Agree	
	1	2	3	4	5
	.7	.7	6.3	32.4	59.9
4. The community in general benefitted.	Strongly Disagree			Strongly Agree	
	1	2	3	4	5
	.7	1.4	10.6	33.1	54.2

n=142

### CONCLUSIONS

The Department of Human Services launched the large scale experiment in January 1996 to ascertain whether a novel approach would deal with social exigencies, such as child abuse and neglect, an inordinate number of placements in foster care, and teen pregnancy. The Family Preservation/Family Support Services Program was an ambitious effort to militate against the increment in the number of children in foster care, a problem that plagues child welfare system nationwide. The state of Mississippi must be applauded for making such a significant endeavor. It must also be commended for including an evaluation of the program. At this juncture, we can attempt to reap what can be learned from the experience of MFP/FSS.

Prior to summarizing the findings of the evaluation, it is of paramount importance to note a significant fact about MFP/FSS as an intervention, namely its variability. In a medical experiment on a new drug, the chemical composition of the medication does not vary from one patient to another (although dosage may vary, the variation can be precisely measured) and the research task to analyze the variation in response of individuals. In the evaluation of social programs, there is almost always variation in the intervention as well as the response of the individuals and families. Variation in the intervention has been particularly great. This program was conducted through 18 sites throughout the state, and within broad guidelines, these agencies have considerable latitude in constructing their programs. The

variation may be thought of as both a virtue and a vice. The variation is considered a vice because of the complications these variations engender for the evaluation effort and a virtue because they allow for the exploration of differences in effects of various approaches to family preservation. Although there was a great deal of variation in the programs, the commonalities shared by the programs were those shared by family preservation and family service programs listed previously in this paper. These commonalities allowed for aggregate analyses of the data.

Further, it is important to note that another major limitation of this study is the quasi-experimental design. This design was not the method of choice but rather a fall-back strategy, because random assignment to a treatment and control group was not possible since the evaluation was retrospective in nature (e.g., the programs were already under way or over). One of the major weaknesses of this method is that the comparison base created may be biased, and therefore it does not provide information about the outcome if a treatment was not given. Therefore, the results of this evaluation should be viewed in light of the limitations.

The primary objective of family preservation programs and therefore the initial concern in evaluations of these programs has been the prevention of placement in out-of-home care. Overall, we found little evidence that this MFP/FSS resulted in lower placement rates as have other studies (Schuerman et al. 1994; Meezon & McCroskey, 1997). Nor did the researchers find evidence that the MFP/FSS has resulted in significant changes in other social maladies, such as teen pregnancy or abuse. However, it is important to note that the program had only been in progress for eight months prior to the commencement of the evaluation, and the total duration of the program was one year and eight months. As noted previously, research has demonstrated that significant changes may take place several months after the termination of the program. This is not a chimerical expectation, i.e., this is not an illusory expectation nor is it improbable. It is because of this probable occurrence that a follow-up study is recommended.

However, there were significant changes in functional support and family functioning. It appears that clients perceived an increase in (tangible support) the availability of material aids, (appraisal) availability of people to talk to, and an increase in (self-esteem support) the availability of a positive comparison when comparing oneself with others after participation in the program. These changes show an increase in specific areas of functional support. Similar changes were found in family functioning where families changed from being disinclined to talking to amenable to talking among themselves to resolve problems. In an endeavor to ascertain an explanation for this change, regression analyses were conducted. Age of clients and the type of intervention accounted for the change in self-esteem subtests



scores. Further analyses show that the greatest mean differences were found in clients ages 40-49 and 50-59. Further scrutiny of the data shows that clients receiving home visits and counseling also had the greatest change in self-esteem support scores. The changes in the age groups cited are probably best explained by the concomitant transitions of the various age groups as defined by Daniel Levinson (as cited in Philipchalk & McConnell (1994)). These age groups probably scored higher after treatment because according to Levinson, age 40 is often coupled with another life transition, which for many is traumatic—"mid-life crisis." At this time, individuals retrospect on unfulfilled dreams of youth and put them into perspective. They must accept the realization that they are not the unqualified success they had aspired to be and that their time is running out. In an endeavor to find new meaning in life, they subsequently explore neglected areas of life. By age 45, most vigorously pursue new more attainable goals with vigor. This is also a period of calm.

Levinson further notes that there is another reevaluation of goals and life style at age 50. If they did not experience a crisis at age 40, they are more likely to by 50. Another period of calm follows. This period is characterized by a time of great fulfillment from reaping the rewards of more realistic goals that were set in earlier periods of transition. A reappraisal of life occurs at Age 60. This appraisal engenders mixed feelings of pride and despair as individuals review their achievements. Quite tersely, the transitions between the ages of 40-69 are dominated by reflections on goals accomplished, an evaluation and reevaluation of goals and lifestyle, the desire to explore neglected areas of their lives in an attempt to find new meaning and reap the rewards of realistic goals. The evaluators therefore surmise that the changes in self-esteem were greatest for clients between the ages of 40-69 because of the evaluation and reevaluation attendant to the various transitions in life. These periods of evaluation and reevaluation could have caused individuals to be more amenable to exploring areas of their lives that had been neglected in an attempt to find meaning. This timely proclivity, coupled with participating in the MFP/FSS, may have engendered a greater increase in self-esteem. More specifically, this population was more cognizant of the areas that necessitated work and therefore sought self-improvement with more vigor than their younger counterparts. This increase in self-esteem is further enhanced by the possibility of individuals being made aware of (through participation in the MFP/FSS) the rewards that they are presently reaping from goals that were set earlier in life.

The evaluators further contend that score gains in self-esteem were higher for those who had home visits and counseling for 2 reasons: (1) family preservation services provide an excellent opportunity to do an ecologically oriented assessment because they involve (home visits where the staff person is brought into the environment of the family, rather than asking the family to enter the environment of the staff person. This provides a chance to learn about the family as a group: the strengths, interests, supports, and needs of the

individuals within the family; the cultural and neighborhood influences; the effect of friends, extended family and other social institutions, like the schools. The staff person learns more about the family's life and is therefore able to be more effective. The family probably feels more comfortable in this setting and is therefore more likely to work toward positive change. The fact that the staff person is coming into the home to work with them may also engender a positive sense of self-worth. Likewise, individual counseling is usually more effective because of the individualized attention. This intense focus or attention on a single family at a time may also precipitate a positive change in self-esteem.

The change in family cohesion was also found to be higher in whites than in their African American counterparts. It is well known that stressors impact family cohesion. There is a negative correlation between the stressors and family cohesion. African Americans experience a greater number of stressors because of racism. More specifically, African Americans experience three kinds of racism: individual, institutional, and cultural. Individual racism is where individuals manifest prejudiced behavior toward African Americans; institutional racism entails the limiting of resources and opportunities because of race; and cultural racism is where the media, churches, schools, etc., perpetuate prejudice. These types of racism are an everyday reality for African Americans. The everyday stressors that one experiences regardless of race are further compounded by the different forms of racism. Therefore, the evaluators contend that although there were mean gains in family cohesion for both races, the gain was not as great for African Americans. It therefore appears that participating in the program did lead to an increase in family cohesion and probably helped families to, at minimum, begin to communicate to facilitate problem resolutions. However, there are other factors that affect family cohesion that were not addressed by MFP/FSS such as stressors emanating from racism and how to cope with these stressors.

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The change in the perception of clients regarding the availability of material resources and availability of people to talk to may be due to the fact that participating in the program provides clients with knowledge of many community resources of which they are usually not aware. The intervention affords them the opportunity to talk with someone who is empathetic to their needs. They may also begin to talk more with family members as the results of this evaluation implies as evidenced by the scores on FACES (Cohesion and Adaptability).

Although the utility of client satisfaction as an outcome measure is rated as medium (Martin & Kettner, 1996) in terms of acceptance, client satisfaction is of interest to a variety of stakeholders. Elected officials, funding agencies (government and foundations), program administrators, and agency administrators are all generally interested in and concerned about clients' perceptions of the effectiveness of human service programs. Most stakeholders also recognize the inherent limitations of client satisfaction data.

Client satisfaction by its very nature is subjective. One can never say without dubiety that the client's assessment is accurate. Nevertheless, client satisfaction data provide an important perspective on the effectiveness of human service programs that cannot be gained from any of the other types of outcome performance measures (Pecora, 1991). The evaluators in this study attempted to assuage the subjectivity and concomitantly increase the accuracy of self report by insuring the clients that the responses to the questions would be anonymous. It is because of the insurance of anonymity and random selection that we can assume with a moderate degree of certainty that the responses are accurate and objective.

Results show that the vast majority of clients felt good about the services they received, the impact of the program in helping them with their problem, the appearance of the facilities, and the humane manner in which the program protected their sense of dignity and pride. These data are important because the data provide information about the client's perception of the program and facilitate the identification of problem areas that may warrant modification for the sake of improvements. Percentages ranged from 89.1% to 95.5% in terms of agreeing to strongly agreeing relative to the quality dimensions discussed in Table 2. Therefore, based on these data, satisfaction with all dimensions appeared to be high. Similarly, overall satisfaction with the program seemed to be high. Attendant to these data

are the data on outcome performance, which demonstrated that clients appear to feel that the program was very beneficial to them. Based on the client satisfaction data, it can be said with a moderate degree of certainty, that the clients felt good about the quality of services received and that the impacts of the program were positive based on self-reports of clients (i.e., clients felt that the program was very helpful in their attempt to solve their problem and in helping them develop vocationally, academically, and personally). Based on these results, there is little need for program improvements on the quality dimensions of interest.

Staff satisfaction is important to the success of a program. Therefore, the assessment of staff satisfaction was conducted to determine staff satisfaction with the program and their perception of the impact of the program. Results indicated that the vast majority of the staff was satisfied with the program. This satisfaction was further manifested in their positive ratings on specific dimensions of the program. Tangentially, the majority of the staff (83.7%-93.7%) felt that the program could help break the cycle of abuse and neglect and reduce domestic violence, violence in the areas served, and strengthen and stabilize families. They further felt that the impact of the program would have lasting benefits.

Another important need in the effort to improve family preservation services is the need for agencies to work together in planning and providing services. According to the data collected from staff members, several community resources (for a listings of resources, see Results) were used. Most staff members (61.1%) reported making referrals outside of the agency. The smallest number of staff members made referrals within the agency (9.3%) and (29.6%) made referrals within and outside of the agency. These data imply that the staff feel positive about the program and the impact that it is having on clients and the community in general. They further report using more outside referrals. This implies that a more collaborative service system is being utilized. The usage of a more collaborative service system was further demonstrated by the larger percentage (91.7%) of staff who reported making referrals that were part of a collaborative community system. It appears that the staff have made valiant efforts to link families with other services that they may need. This too may also account for the change in perceived availability of material aids.

Community perception and support is extremely pertinent to the success of family preservation programs. In this vein, data collected on community perception indicated that the vast majority of the sample (83.9%-92.3%) felt that the program has been very effective, had helped strengthen families, had benefitted the community in general, and would have lasting benefits. These data indicate that the perception in the community regarding the overall impact of the program is very positive.



In sum, although it appears that MMFP/FSS was not successful in producing positive changes in foster care placement, abuse/neglect, or teen pregnancy rates, contrariwise, significant changes did occur in family functioning and some dimensions of perceived functional support. To generate a more comprehensive picture of the program, other dimensions were examined: client satisfaction, staff satisfaction, and client-, staff- and community-perceived impact of the program. Results indicate that satisfaction among clients and staff was high and that all three groups (clients, staff, and community) felt that the program was effective and had a positive impact on clients and the community in general. Additionally, the usage of a more collaborative service system was further demonstrated by the larger percentage of staff who reported making referrals that were part of a collaborative community system. It appears that the staff have made valiant efforts to link families with other services that they may need by using a collaborative service system.

### Recommendations

The MFP/FSS represented a dramatic improvement in the responsiveness of the child welfare system to address the needs of families. In addition to responding more quickly to these needs, the program represented improvements in the quantity and quality of services provided to clients. The fact that these changes did not result in more substantial benefits for families is certainly disappointing. However, given the complex nature of the problems that bring families into contact with the child welfare system and the limited time of the program (1 year-8 months), it seems unrealistic to expect many changes in families as a result of short-term family preservation efforts. Further, the changes in family functioning and functional support were significant in spite of the short-term family preservation effort. Short-term intervention is appropriate in many cases, but not in all cases. Some families are able to benefit from this kind of service, but others require more extended work. Many cases involve problems that will not be resolved in a short-term service, regardless of the intensity. Long-term problems tend to require long-term treatment. Therefore, it is recommended that a range of service lengths and intensities be available to families. Perhaps more important, much more attention needs to be paid to what happens at the end of the program and afterwards. Research has demonstrated that positive changes sometimes occur 3 or 6 months and sometimes even later after termination. It is therefore recommended that follow-up studies be conducted to determine whether such changes have taken place.

Results also demonstrated that the increase in family cohesion was greater for whites than African Americans. Such changes were less for African Americans because of the added burden of concomitant stressors of racism. Therefore, it is important that all staff members are cognizant of the life experiences of African American families and can provide them

with coping skills requisite for their survival and success. Commissioning clinical psychologists to present workshops on counseling the culturally different families is recommended.

The program is to be commended for the quality services provided as reported by both clients and staff. Scores were high on all quality dimensions.

Additionally, another commendable and likely fruitful direction taken by MFP/FSS was the development of smaller, specialized programs for client groups. Family preservation programs are usually "generalist" programs requiring agencies to deal with a wide range of problems. As a result, the acquisition of expertise in dealing with particular problems is inhibited. An additional enhancement would be to group clients by various demographics as well as problems. Demographics such as age, gender, and marital status have common tangential problems and perspectives that can determine the kind of intervention and the results. Age proved to be an important predictor of self-esteem in this study, while race was an important predictor of family cohesion.

Results also demonstrated that the more individualized interventions and intervention in which the staff went into the home (home site visits) was more effective in increasing self-esteem. It is therefore recommended that adequate staff be hired to provide more counseling and more home site visits should be made.

The MFP/FSS also proved to involve usage of resources that have not been used as often in the past. There were many more alternatives for families and staff who were assisting them. The referral of families to collaborative community-based services helped them with a number of problems, such as housing problems, support for parents, etc. Often, help of this nature is provided too late, after family relationships have deteriorated. This help should be more universally available through community-based organizations that are responsive to the needs of their neighborhoods.

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## Ordinary Families — Extraordinary Care Giving

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**John P. Ronnau**

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*Children with severe emotional problems often have multiple needs that require disparate services including child welfare, juvenile justice, health, mental health, substance abuse, and mental retardation (Stroul, 1996). However, the primary care giving responsibilities for these youngsters still remain with their families. It is the family who shelters and clothes them; provides guidance, affection, recreation, nurturing; gets them to appointments with doctors and therapists and to school day-in-and-day-out, year after year (Lourie, 1995). Despite the invaluable and irreplaceable care provided by families, they are often maligned by a system which characterizes them as having their own problems and inadequacies.*

*The purpose of this research is to learn more about the strengths of families who care for children with severe emotional disabilities (SED). This exploratory descriptive study made use of focus groups attended by parents who are caring for such children. In order to improve services to these families, it is important that we understand how the notion of strengths play out in their everyday lives. Observations are made about the care giving plan, which all families devise in the course of caring for their child with special needs. Implications for paid professionals who serve these families are offered by presenting a model for putting family care givers at the hub of the service provision wheel.*

### Needs of Youth with SED

United States' estimates of the number of children ages 4-18 who have some type of diagnosable mental disorder range from 14% to 26%, with 7% having a serious disorder (Nixon, 1997; Rog, 1995; Stroul, 1996). However, only 20% to 30% of these children actually receive services (Nixon, 1997; Rog, 1995; Stroul, 1996). Children's mental health problems cover a wide range of disorders, including depression, anxiety, conduct, and developmental disorders. Diagnosis of children's mental health problems is especially difficult, because they may have multiple disorders, being effected by interrelated physical impairments, developmental issues, and environmental factors (Rog, 1995). Most definitions of severe emotional problems in youth (under 18) include the following characteristics: exhibiting severe behavioral, emotional, or social disabilities; these disabilities disrupt normal development and have persisted for an extended period of time;



the disabilities cannot be attributed solely to intellectual, physical, or sensory deficits; and the youth frequently requires intensive treatment (Ronnau & Poertner, 1989). "These children require a range of mental health services which are age appropriate and at varying levels of intensity. However, mental health services alone are not enough. Emotionally disturbed children almost universally manifest problems in many spheres, including home, school, and community. As a result, they require the intervention of other agencies and systems to provide special education, child welfare, health, vocational, and often, juvenile justice services" (Stroul & Friedman, 1986, p. v).

Caring for a child with a severe disability places tremendous strain upon the family and exacts a high cost (Bush, 1985; Wason, 1995). Among the stressors experienced by family care givers of these children are financial costs, stigma, constant worry and anxiety, guilt, social isolation, interruptions of sleep, limitations in recreational activities, interruption of normal routines, feeling pessimistic, and increased sibling conflict (Freeman & Simmons, 1974; Goldman, 1982; Marcus, 1977; Moroney, 1981; Thompson & Doll, 1982; Willis, 1982). Providing the structure, guidance, support, and specialized treatment that these children need is a complicated and demanding challenge.

### Historical Focus on What Families Do Wrong

Despite the fact that families provide the preponderance of day-to-day care that children with SED need to function in the community, many still perceive of themselves as being on the outside of the service system looking in. Too often, they are treated as outsiders, irritants, nuisances, and as the source of their children's problems (Stroul, 1996; Turnbull & Turnbull, 1986). Causation theories that finger point at these parents have caused many to feel guilt, resentment, low self-esteem, lack of trust, and defensiveness (Turnbull & Turnbull, 1986). Barriers to constructive parent-professional relationships have been erected, which prevent the service system from capitalizing upon the energies of the most invested service providers, the parents. It is the parents who often have the most knowledge about their child's history and needs, are the most committed, and who spend the most time with the child. The Stinnett and Sauer (1977) observation from two decades ago still applies today: "most of the research, as well as most of the popular writing, in the area of marriage and the family has focused upon pathology. Too little is known about the psychological and social factors that contribute to family strengths" (p. 5).

Most families who care for children with special needs are doing the best they can with what they have under extremely challenging and stressful circumstances (Lloyd & Sallee, 1994; Ronnau & Poertner, 1993; Turnbull & Turnbull, 1986; Weick & Saleebey, 1995). Most are highly committed, caring, capable, intact families. In the author's opinion, the vast majority

of these families do an admirable job, though they may occasionally benefit from timely and measured assistance. We need to improve our assessments to recognize the parents who need intensive help. Some may appear "dysfunctional" at a given point in time due to care giving demands and stress; however, only a small percentage are incapable of caring for their children.

Early and Poertner (1993) contend that a "normalization approach" should be used with children who have SED to reduce stigma and prevent unnecessary institutionalization. Similarly, one may think about freeing up the service system to make better use of family energies, skills, knowledge, and commitment in caring for their troubled child. "When families are assumed to be at fault for their children's problems, families are not considered to be a resource for their children; rather, they are something to be 'fixed' or removed from their children's lives through placing the children out of their homes" (Early & Poertner, 1993, p. 748).

### The Value of Family Care Giving

"The most important asset for a child with a serious mental disability is a *close relationship with his or her family* (or surrogate family), no matter how stressed or in pain they may be at any given time" (Cole, 1995, p. 193). It is ironic that those paid to help may actually hurt the efforts of families, unwittingly and certainly unintentionally, but the effects are no less harmful. McKnight (1995) has articulated the negative impact that paid professionals can have upon families. He stated that "through the propagation of belief in authoritative expertise, professionals cut through the social fabric of community and sow clienthood where citizenship once grew" (p. 10). It seems that somewhere along the line, we have turned the conceptual pyramid on its head. Instead of families, neighborhoods, and communities being in their rightful place as the foundation of care giving, child rearing, and nurturing law abiding citizens, people paid to "care" have taken their place as what modern society values most. Human service professionals are paid large sums of the tax payers' money to try and duplicate what families have always provided (Adams & Nelson, 1995; Levenstein, 1981).

The point is not that families are perfect nor that there is no need for paid professionals. The point is that our best hope is to learn more about what families do right so that we can learn how to help them do their job. Nothing can take their place in this care-giving equation (Stroul, 1996). "The family unit then, must be the primary object of therapeutic attention and, individually or as a group, family members must become primary participants and, as soon as possible, leaders in the treatment process" (Cole, 1995, p. 193).



The family-centered movement is a significant sign of hope for those who believe, and practice accordingly, in the central role that families must play in caring for persons with special needs.

Family-centered work starts from the recognition that professionals are not at the center of helping systems, that most of the caring and controlling in which social workers, nurses, teachers, probation officers, and even the police engage is done by others—families, kin, and neighborhood networks, informal groups, churches, schools, and other formal organizations. The effectiveness of human services depends on how well they interact with the whole complex of formal and informal elements to strengthen the community's capacity to care for its members and address shared needs and concerns (Adams & Nelson, 1995, p. 6).

The basic premise of what Adams and Nelson (1995) refer to as the "decentering" of human services is to "recognize that most of the caring and controlling in the community is normally done informally within families and neighborhoods. The task of the professionals then, is to find ways to join the community and help it in carrying out *its* work of caring for its members" (p. 7). Rapp, Shera, and Kisthardt (1993) assert that use of an "empowerment paradigm" will help us make best use of family strengths. They stated:

Some of the central features of the emerging empowerment paradigm include treating clients as subjects rather than as objects; focusing on clients' strengths rather than on pathology; clients actively participating throughout the helping process; seeing resources as the total community rather than just as formal services; emphasizing the rejuvenation of informal social networks; and monitoring, evaluating, and advocating in a collaborative fashion (p. 728).

Similarly, Lawson (1996) and Briar-Lawson (1997) describe "new partnerships" for improving service systems, which must include families in integral ways. McKnight (1997) talks about the importance of valuing families and the "associational community" over formal service systems. An effective way to help families do their job is to learn about and make use of their strengths.

### Methodology

This research was carried out to answer the question: what are the strengths of families who care for children with severe emotional disabilities? This exploratory descriptive study employed an interview-guided approach. This approach was the most desirable compromise between a highly structured or a completely open-ended approach (Rubin & Babbie, 1997).

A qualitative design is appropriate because the research was conducted in the natural settings of the respondents; the variables being studied did not lend themselves to being controlled, tested, or manipulated; the information (data) provided by the respondents was influenced by their life experiences and priorities; and the primary means of analysis was to assess themes which naturally emerged from the data (Tutty, Rothery, & Grinnell, 1996). As with all research endeavors of this nature, there were both advantages and limitations. The interview guide provided systematization to the data collection process. The advantages of this were two fold: (1) it allowed for consistency across the three sites where data were collected, and (2) it provided some insights and guidance for respondents in an area that was otherwise unique to them. The limitations included threats to both internal and external validity, which were not controlled for; accordingly, no overt claims of generalizability can be made (Campbell & Stanley, 1963).

### Sample

The sample consisted of forty-two parents (N=42) in four sites. Three of the sites were communities in the Southwestern United States. The fourth site was a workshop included in a national conference on family strengths. Twelve (12) of the parents self-identified as Hispanic, 8 as Native American, 1 African American, and 21 Caucasian. While four couples participated in the discussions, the bulk of the respondents represented different families. More than 90% of the participants were female. Most of the families were of modest economic means, though some of the single parents reported that they struggle financially to make ends meet.

Each of the families represented in the sample was caring for at least one child with SED, for a total of 38 children. The children's ages ranged from 3 to 18, with an average of 10.5 years. Modal age is 7 (seven children). The diagnoses assigned most frequently to the children in the sample were Attention-Deficit/Hyperactivity (70%), Oppositional Defiant (30%), Childhood Depression (10%), and Conduct Disorders (10%). Percentages are approximate. Several of the children had more than one diagnosis.

Participants were included in the study by means of purposive sampling (Grinnell, 1993). The parents were identified through local chapters of Parents for Behaviorally Different Children (PBDC), a nationwide advocacy group for families caring for children with SED. They were invited to attend the session by a local PBDC representative via telephone or mail. All participants were asked to sign a consent form, and their confidentiality was assured.



### Instrumentation

The 42 parent participants were asked to think about, discuss, and list their strengths in terms of seven categories. Family functions identified by Turnbull and Turnbull (1986) comprised six of the categories. The family-functions framework was developed to remind professionals about the "total context" of family care giving. These functions are the areas of responsibilities within which a family does its job (i.e., to meet the needs of its members). They also have proven useful areas in which to look for the strengths of families (Ronnau & Page, 1991). The six family functions are

- domestic (e.g., meeting basic needs such as food, clothing, shelter)
  - self-identity (e.g., self-esteem, developing positive self-image)
  - affection (e.g., nurturing, showing love and caring)
  - socialization (e.g., setting limits, providing guidance)
  - recreation (e.g., fun, relaxation)
  - education/vocational (e.g., school work, skill development)
- (Turnbull & Turnbull, 1986, p. 68-69)

An "other" category was included to allow for the identification of strengths which fell outside of the family-functions framework.

### Data Collection

After introductions and assurances of confidentiality, the purpose of the interview was explained to the participants. The parents then were asked to meet in groups of three and appoint a recorder. They were encouraged to openly discuss and then list the strengths they have observed in their own and other families caring for children with SED. After approximately an hour of discussion, the large group was reconvened. Each group was asked to report their findings. The lists compiled in the small groups were collected at the end of the meeting. The same data collection process was followed in each of the four sites.

### Analysis

A total of 489 strengths were listed by the respondents. The strengths in each category were analyzed to search for themes. A theme was identified when a cluster of comments reflected the same strength. The size of the clusters within the first six categories ranged from 45 to 6, with an average of 15. The cluster sizes in the "Other" category were 7 and 6. The threshold for identifying a cluster was different for each category because the total number

of strengths listed in each category varied. A common cut-off point across all categories would have hidden some important themes.

### Findings

One of the most valuable aspects of qualitative research is that it allows the respondents' "voices" to be heard. It is unfortunate, in that regard, that space limitations do not allow listing all the responses in each of the themes; instead, only representative comments are given. The number in parentheses following the main categories is the total number of strengths which were listed. Similarly, the number of strengths listed in each theme (i.e., the cluster size) is reported.

#### Strengths in Meeting Domestic Needs (84)

In the category of domestic family strengths, four themes emerged: *providing basic economic support, adapting schedules to meet the child's needs, obtaining specialized care, and meeting medical needs.*

##### I. Basic Economic Support (45)

- My husband and I both work to provide money to pay for our house payments and utilities
- Full-time work to provide food, clothing, and pay the mortgage
- Learn which foods help or harm
- Adjust diet, learn what helps with moods
- Provide a balanced diet
- Meals, wash clothes, bath

##### II. Schedules (8)

- As a single parent, I work part-time. I try to be home early so that when my child gets home from school, I spend as much time with him as possible, get his snack, make it structured
- Try to make my work schedule as flexible as possible so that I can be with the kids as much as possible and change shifts with my wife's hectic schedule (both my wife and I take turns a lot taking care of the kids, clean house, cooking, clothing them)
- Rearrange my work schedule to accommodate my child, so he can get into a schedule



- Finding work that will compliment my son's schedule

### III. Specialized Care (8)

- Monitor sitter and ask on a daily basis how the day was
- I have my mother and one of my boyfriend's aunts help me out with my daughter to pick her up after school
- Finding proper care for when I'm working
- Special needs sitters

### IV. Medical Care (6)

- Getting doctors that know something about ADHD
- Make sure he takes his medication
- Making sure he gets all his medication
- Knowing your medicines

It is not surprising that providing economic support is a predominant theme. It is the basic challenge of all families, especially single parents. Similarly, many parents must juggle schedules to be when and where their children need them. The last two themes, however, are particularly relevant to the needs of children with SED. Finding competent baby sitters or after school care for children with severe behavior problems is a frustrating challenge. Also, many of these children are prescribed medication. Parents must be sure their children take the medicine, often involve the school in administering it, get the prescriptions refilled, and monitor for side effects.

### Strengths in enhancing Self-Identity (85)

Three themes emerged from the list of 85 developed by respondents related to the development of self-identity in their children: *providing encouragement, confidence building, and enrollment in special programs.*

#### I. Providing Encouragement (29)

- Telling them good things about themselves
- Thinking positive
- Praise for their achievements, a lot of kind supportive words
- Always assure him he will be supported
- Praising his good report cards and good school papers

- Tell him how smart he is

#### II. Confidence Building (14)

- Finding things for them to do at which they can be successful
- Giving him chores that he can succeed in then immediate reward or praise
- Encouraging self-help skills
- Telling him that he can do anything he sets himself to do like bathing, dressing, basic needs that are not so easy for him to accomplish

#### III. Special Programs (8)

- My son, who is very emotional, and has trouble with bullies, is now in therapy and a support group
- Entered into family counseling for behavior management
- Enrolled her in school self-esteem program

Providing encouragement and building the confidence of their children are characteristic of all good parents. However, many children with SED need an incredible amount of this reassurance because of their low self-esteem. Finding and attending special programs in order to meet their child's needs, requires a disproportionate amount of these parents' time.

### Strengths in providing Affection (72)

A total of 72 strengths were listed by the parents. Two themes are observed in the list: *providing verbal reassurance and physical contact.*

#### I. Providing Reassurance (17)

- Ask them how their day has been and what they ate
- Use affectionate names
- Asking about how they feel
- Praise good actions

#### II. Providing Physical Contact (14)

- Tickling and cuddling
- Backrubs, footrubs, to soothe
- Lots of hugs



- We do a lot of hugging and holding. The girls need to cry and cry sometimes while I hold them and murmur and stroke them

The strengths listed by the parents of children with SED in this category, perhaps more than any of the others, resemble what we would expect to see in a list of strengths of any "good" and nurturing parent. The difference is in the frequency and intensity of affection and other kinds of reassurance required by these children. For many of them, physical contact can be both a trigger for acting out or have an almost magical calming effect. Knowing when and how to touch their children is an art developed by many of these parents.

### Strengths in providing Socialization (65)

The parents listed 65 strengths in this area. Two themes were evident in their list: *setting limits and providing opportunities for socialization*.

#### I. Setting Limits (25)

- Punish the kids if they go out into the street
- Give consequences for different behaviors
- We try to correct and redirect his social behaviors without making him feel bad
- Setting limits and boundaries

#### II. Providing Socialization Opportunities (9)

- Have her friends spend the night
- Include other children in activities on the weekend. I try to create a social environment for her in this way
- Take him places that meet his needs—the right place at the right time

Socialization is a major parenting responsibility in all families. The strengths listed by parents of children with SED suggest that limit setting is even more of a challenge in their families. Their children require continual reminders and redirection.

### Strengths in providing Recreation (66)

The list of strengths in the area of recreation totaled 66. One theme was observed: *managing excessive energy*.

#### I. Managing Excessive Energy (10)

- Let him tantrum thru
- Massage therapy
- Sit wrapped in his favorite blanket
- Scratching his back when he goes to sleep
- Lot of outdoor things to vent feelings and energy

The list of strengths in this category appears similar to the recreational activities one would expect to see in all families, with one notable exception. The theme which emerged reinforces the observation that many children with SED need help to slow down and relax. Their parents must be vigilant and deliberate in providing them the time and safe space in which to vent their excessive energy and exuberance.

### Strengths in Meeting Education/Vocational needs (77)

The parents listed 77 strengths in this category. The four themes which emerged from the list are: *advocating; encouraging school attendance; accessing special programs; and obtaining information*.

#### I. Advocating (20)

- Keep in close contact with teacher and counselor
- Attend IEP meetings
- Became advocate for special needs kids
- Advocating for special programs at school
- Follow-up. Making sure that his IEP goals meet his needs
- Many, many meetings at school, IEPs or 504s

#### II. Encourage School Attendance (19)

- Daily notes to teacher to let her know and for her to let me know how his day (or night) went
- Work with her teacher on a daily basis
- Being involved in what's happening at school
- Reinforce how important school is



III. Accessing Special Programs (8)

- Take classes on parenting
- Having to find programs to fit special needs
- We have tried hard to find proper academic settings for our children, including paying for private school

IV. Obtaining Information (6)

- I've had to become an expert on Dyslexia, ADD, and other learning differences in order to get them what they need in school
- Learned about his disability for behavior medications
- I come to school meetings to see how my daughter is doing in school

The education/vocational category of strengths is the one in which the extraordinary efforts of these parents show up most dramatically. School is a dominant theme in the lives of all youngsters and, therefore, in the lives of their parents. In addition to parent-teacher conferences, sports, and all the other "normal" activities that kids get involved in, parents of children with SED must attend many more meetings because of their child's special needs. For many of these children, any hope of having a successful school experience requires their parents to be in constant communication with teachers and other school personnel.

**"Other" Strengths** (40)

A total of forty "other" strengths were listed by the respondents. Three themes emerged from the list: *patience, commitment, and advocacy*.

I. Commitment (7)

- My child means everything to me and I will do anything and everything to help him!
- We don't give up. If it doesn't work we try something else
- Never, ever, ever gave up

II. Patience (6)

- Being able to be patient and keep up with him—better than most people could
- Patience, sense of humor, commitment

- Patience, honesty, dedication in providing the best for her

III. Advocacy (5)

- My wife formed a parent advocate and support group
- Being parent advocate for autism program
- Advocacy for special needs kids

The list of "other" strengths provides insight into what the parents themselves see as important for caring for their children. Commitment and patience are required in abundance from all parents but even more so for those caring for a child with SED. While all parents at times are advocates, these parents must often fight to obtain even the basic services for their children.

**Practice Implications**

The results of this research support the observation that caring for a child with special needs requires all the "normal" strengths seen in most "healthy" families, plus the extraordinary ones observed in this study. This extraordinary care giving is conceptualized as an Individualized Care Giving Plan (ICGP). Depicting the family's responses over time as a "plan" is meant to denote that they continually test, adapt, and revise their approach to caring for their child with special needs. While there may not be a plan in the formal sense of the term, the author suggests that families that successfully care for a child with SED over time do, in essence, develop a plan as they respond, adapt, and respond again to their child's needs. Figure 1 depicts this special plan.

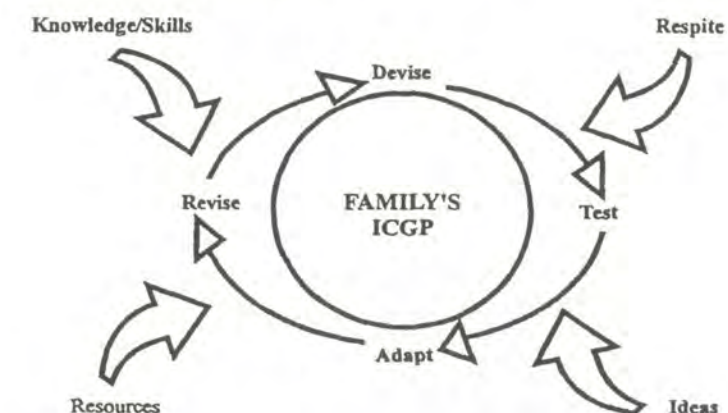


Figure 10. Family's Individual Care Giving Plan (ICGP)



The family is at the center to reflect the reality that family members provide the bulk of the intensive and sustained care required by children with special needs. If a child with SED is to grow into a healthy adult, the service plan must "wrap around" the family, instead of taking the place of, or in any way diminishing, the family's role. As Elizabeth Cole puts it "the participants in the system of care are viewed, in terms of some order of influence, as the concentric layers of the famous onion. The child's family (or surrogate family) is the first layer, most intimately involved, and directly responsible." (Cole, 1995, p. 192).

As depicted in the second circle, parents devise a plan for caring for their child. Simply put, they must continually come up with ideas and solutions. Then, they test those ideas through application. They must revise those plans and test them out. No plan is perfect and children can be very unpredictable! There are so many variables that cannot be anticipated. So parents must be adaptable. McIntyre observes that "constant restructuring in small increments contributes to overall stability in organizations and living systems—maybe families can benefit from this knowledge as well" (McIntyre, 1997, p. 4). Indeed, we should expect, predict, and celebrate the many "failed experiments" families will engage in during the process of caring for their children.

The outer circle depicts the inputs provided by workers to help families. Often what families need most are concrete and practical resources. For some, it will be help in finding transportation to appointments; for others, it will be money to buy medicine, or diapers, or pay the rent, or keep the utilities on. Many of these families need respite, which will require specialized care givers. Others need information and help to learn new skills. What does a "conduct disorder" really mean? Why did the doctor prescribe Ritalin? What will it do to my son? How do I stand up for my daughter without being labeled "an over involved parent?" Emphasizing the strengths of families does not mean that they can always go it alone. What we know about the needs of children with SED is that their families will need lots of support from friends, extended family, community, and paid professionals in order to do their jobs.

This way of working with families requires a paradigm shift. Who is really at the hub of the care giving wheel? Who provides the bulk of the most intensive and long-term care? Who is likely to be there day in and day out for the child? Who are the people who "never, ever, ever gave up" on their children? That's who should be at the center of the care giving plan. The focus of paid professionals should be on supporting their efforts.

Based upon the results of this research and all that the author has learned from working with parents caring for children with SED to date, these practice guidelines are offered:

- Just because the family is not being paid does not mean the care giving has no value;
- Even though the care giving is not perfect, does not mean it is inferior (a 24 hour per day job provides lots of opportunities to commit imperfections); and
- Family care givers are the long-term committed care givers and the child's most important resource; therefore, the paid professionals' primary role should be to support, not supplant, the family's efforts.

Family members may or may not have certificates or degrees attesting to their knowledge, and they are not paid for the care they provide to their children. The irony is that while it often is not valued, the care these families provide is priceless. In most cases, the state cannot match the quality of the "holding environment" which families provide. Just because the family is not being paid does not mean the care giving has no value; in fact, family is the most valuable resource the child has.

Our perceptions and expectations of people have powerful effects. If we expect a family to be resistant and dysfunctional, they probably will be. But if we begin our work with them by listening to their story, avidly looking for their strengths as we assist them to meet their needs and resolve their problems, we may discover and free up tremendous resources. Blaming is unproductive. "Being on the outside looking in, while various professionals fasten labels and lay blame for the (mis)behavior of their child, can only render families unable or afraid to try their own solutions to problems" (McIntyre, 1997, p. 3-4).

### Conclusion

Adams and Nelson assert that instead of waiting until the family collapses from fatigue or lack of resources, paid professionals "need to recognize and support, even give respite to, those who bear the main burden of care" (Adams & Nelson, 1995, p. 6). Orthner and Cole recommend development of "community-based strategies" to support families. "Whether through churches, the work place, or community centers, families need resources to supplement the support they receive from friends or relatives in times of trouble" (Orthner & Cole, 1997, p. 4). Instead of imposing our own agenda, paid professionals should first listen, observe, and ask about what the family does well. What have they tried? What have been their successes? What have they learned from their "failures"? "What supports, relationships and energy are required to build success for that family?" (McIntyre, 1997, p. 3). The care giving provided for children with SED by their families is invaluable. The priority for paid professionals should be to keep the family and its strengths at the center of the picture in order to best support their efforts.



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## Review of Current Resources



**Sells, Scott P. (1998) Treating the Tough Adolescent: A Family-Based, Step-by-Step Guide. New York: The Guilford Press.**

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*Treating the Tough Adolescent* is about changing the behavior of adolescents who engage in a range of often extreme behavior destructive to themselves and those around them. It is a valuable book that shapes research-supported ideas into practical guidance for professionals working with families of troubled adolescents. It offers a sensible and strategic approach based on 15-step family empowerment model that operationalizes the major practice principles and tests these ideas by carefully analyzing cases from a 4-year process outcome research study. The steps are designed as guidelines that are detailed, but adaptable to different situations. The proposed model uses a family-based approach because Sells believes that changes in the family structure during adolescence have a tremendous impact on a teenager. The central focus is the alleviation of the presenting problem through a return to parental authority, which changes the structure that, according to the author, creates the behavioral problem in the first place.

The book has twelve chapters organized into four parts. **Part I** offers six basic assumptions about the causes of severe behavioral problems with the guidelines necessary to address each of these six causes and then presents a treatment model that includes 15 specific procedural steps for treating families with difficult adolescents. Actual case examples are used to highlight and clarify major points within each step of the model. **Part II** presents five key principles within the 15-step model that are essential for promoting change with the family hierarchy. **Part III** outlines specific strategies addressing special treatment issues, such as working with outside systems; single-parent families; divorce and step-family problems; and alcohol and drug-use. **Part IV** describes how the author uses process-outcome research methods to refine key theoretical concepts within the proposed model.

*Treating the Tough Adolescent* has a number of theoretical and practical strengths. Sells uses straightforward language and exhaustive detail to present the treatment model and it is logical, practical, considerate, and easy to follow. Numerous case examples, flow-charts, and eco-maps are provided with a road-map of procedures, techniques, themes, and therapeutic maneuvers that can be used in every day practice.

The greatest limitation of the book lies in its attempt to validate the model. Sells presents an overly detailed, chronological history of the process-outcome methodology used to construct the model. The methodology is suspect because of its acknowledged psychometric flaws. The results must be viewed with caution due to the biases used in selecting the sample of cases to be studied, which resulted in a tendency to report only favorable incidents. However, the author warns the reader that the model should be viewed as work in progress and that those using it may help refine and develop the model further by contacting him at his web page.

*Treating the Tough Adolescent* is geared mainly for family practitioners working with troubled adolescents. However, it is an excellent resource for any practitioner working with children and families. In addition, many parents who want help in understanding their children, or a practical guide for dealing with the problems they encounter on a day-by-day basis, would find this book both useful and enjoyable.



**Patterson, JoEllen, Lee Williams, Claudia Grauf-Grounds, and Larry Chamow. (1998) Essential Skills in Family Therapy: From the First Interview to Termination. New York: The Guilford Press.**

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The profession of marriage and family therapists will be strengthened by the contribution of this comprehensive text which includes managed care, holistic and spiritual assessments, information necessary for working with families in the 1990s. Operating from a biopsychosocial framework, the two hundred and thirty-page book is written for beginning level marriage and family therapists.

In the twelve chapters, therapists will find insightful information and case illustrations pertinent to critical issues facing the client and the new practitioner. The first chapter encourages the beginning clinician by articulating the fears of both the client and the novice therapist. The authors offer three stages of therapist development. The next two chapters, two and three, talk about before and after the initial interview. Dealing with families' expectations and anxieties and the importance of the joining of the therapist with the client are emphasized as well as the handling of administrative issues, such as fee payments and client permission for videotaping and observation.

Skills in conducting assessments, developing a treatment focus, and using basic counseling skills are the major emphases for the next three chapters, four to six. Chapter four offers practical assessment summaries for batterers, battered women, abusive and nonabusive families, substance abuse, holistic, and spiritual issues. Chapter five comparatively reviews four major theories of Bowen, Minuchin, Haley, and Satir using a case vignette to illustrate the different approaches of historical, structural, process, or experiential frameworks. Working with families and children, couples, and a family member with mental illness

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dominate the next three chapters, six to nine, with the last three chapters focusing on termination, resistance, and future issues like managed care.

The clearly written book has its biggest strength of being comprehensive and insightful to the many dilemmas plaguing new therapists. Although it briefly mentions the need to be culturally sensitive in a couple of the chapters, depth is lacking as to how the therapist needs to integrate the cultural knowledge into assessments and treatment planning. The book is very appropriate for beginning level graduate social work practice and marriage and family classes. It certainly is an excellent contribution to the literature.

**Kagan, Sharon L. and Bernice Weissbourd, Editors. (1994) Putting Families First — America's Family Support Movement And The Challenge of Change. San Francisco: Jossey-Bass Publishers.**

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Sharon L. Kagan and Bernice Weissbourd, respected leaders in the early childhood education field, have contributed much to the family resource movement since its inception two decades ago. As editors of *Putting Families First*, they have brought the contributions of distinguished scholar-practitioners and administrators. In this extensive volume, they have clearly accomplished their goal of exploring recent changes in family support programs and analyzing the family resource movement in the U.S.

The contributors consider a range of topics, including changes in family support in settings, such as schools, child health care, social services, and criminal justice; programmatic and policy changes — and challenges — at the local, state, and federal levels; and issues of quality control, outcome evaluation, and professional education. In particular, the authors describe the changes that have taken place in service delivery as family support principles

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and strategies have been embraced by established agencies and institutions. In addition, they examine the growing body of knowledge that is increasingly available to inform program decisions.

Above all, this book presents an extensive and insightful examination of the evolution and future of family support. The authors are not only knowledgeable but also able to look critically at the current state of the art and raise provocative questions in each area. Several chapters are exemplary and useful to read first, as follows. Urie Bronfenbrenner and Peter R. Neville provide an international perspective, highlighting the lack of family — supportive policies in the U.S. in comparison with international standards. Bernice Weissbourd points to the potential for building a family-supportive nation on the basis of a humanitarian value system. Kagan and Weissbourd, in the concluding chapter, look to the future and argue that "family support is an evolving, dynamic movement at the cusp of significant change" (p. 489).

This volume can certainly contribute to the process of change envisioned by the authors, as it guides interested readers not only in building on what we have learned from two decades of experimentation, practice, and dialogue — but also in looking boldly to the future. It is especially valuable as a resource for administrators, researchers, and educators. In particular, the latter could assign selected chapters to complement required texts in courses in the areas of family-based services, family preservation and child and family welfare.

**Lewis, Susan Lewis and Jeremy Lewis, Editors. (1996) The Work-Family Challenge – Rethinking Employment.  
Thousand Oaks, California: SAGE Publications, Ltd.**

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The nineteen authors, whose works are presented in the series of twelve articles that comprise this publication, represent an impressive array of academic, business, and organizational experts who examine issues related to family and work role tensions. Articles are organized into three major categories that focus on (1) the contexts of reconciling employment and family-based role conflicts, (2) prevailing employment policies and practices that foster work and family role tensions, and (3) barriers related to improving the compatibility of family and work role responsibilities.

A common theme presented in the articles is the belief that contemporary work organizing patterns remain inappropriately anchored in a manufacturing oriented economic context, which traditionally requires the adult male to be employed outside the home and the adult female to function as the homemaker and primary child care provider. The changing nature of work within a growing globally, service-oriented economy produces economic, socio-political and psychological impacts on family units which are undergoing profound structural changes. A global economy, for example, requires greater work productivity, product quality, and the need for a flexible labor force, along with rapid responses to new technologies and changing markets. The changing nature of work-family tensions is further exacerbated by the growing need for both adults to be employed and to simultaneously care for dependent children and parents as their life expectancy increases.

Within broad international, national, socio-political, legislative, and economic contexts, this publication provides an excellent, introductory overview of relationships between workplace organization, policies and practices, and family role responsibilities of labor force members. The presentation of dominant European and U.S. employment and work organization practices provide a broad perspective on employment and family role tensions and the range



of change strategies needed to improve work-family compatibility. Changes in the beliefs, values and norms that comprise organizational cultures and the work structures that flow from these values, the authors argue, must be adapted to better reflect the actual characteristics of contemporary work force members. A combination of theoretical and case studies enables readers to examine the need for mutually beneficial reciprocity between employers and their employees which can result in improved organizational effectiveness, while simultaneously providing opportunities for employees to meet family and civic role responsibilities.

The broad theoretical overview of family and work role compatibility results in leaving the reader with a lack of practical approaches that have actually been applied and evaluated in contemporary organizations that have strived to become more family-friendly. The strategies and corporate examples that are provided present a useful theoretical overview, but lack specifics suitable for replication of business practices and personnel policies. Examples of very practical ways that have actually improved the family-friendliness of the employing organizations are needed. The reader does acquire from this publication, however, a thorough and comparative overview of issues, needs and trends related to work-family role conflicts. Consequently, the publication provides a basic conceptual examination of the major issues inherent in reconciling work organization personnel practices and policies with family-based role responsibilities of a work force. Actual change-oriented strategies and tactics designed to improve the compatibility of these interrelationships must be obtained elsewhere.





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